

105TH CONGRESS  
1ST SESSION

# S. 904

To amend title XVIII of the Social Security Act to provide medicare beneficiaries with choices, and for other purposes.

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IN THE SENATE OF THE UNITED STATES

JUNE 16, 1997

Mr. BREAUX (for himself, Mr. MACK, and Mr. KERREY) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To amend title XVIII of the Social Security Act to provide medicare beneficiaries with choices, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

3       **SECTION 1. SHORT TITLE; AMENDMENTS; REFERENCES;**

4                       **TABLE OF CONTENTS.**

5       (a) SHORT TITLE.—This Act may be cited as the  
6       “Comprehensive Medicare Reform and Improvement Act  
7       of 1997”.

8       (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-  
9       cept as otherwise specifically provided, whenever in this  
10      Act an amendment is expressed in terms of an amendment

1 to or repeal of a section or other provision, the reference  
 2 shall be considered to be made to that section or other  
 3 provision of the Social Security Act.

4 (c) REFERENCES TO OBRA.—In this Act, the terms  
 5 “OBRA–1986”, “OBRA–1987”, “OBRA–1990”, and  
 6 “OBRA–1993” refer to the Omnibus Budget Reconcili-  
 7 ation Act of 1986 (Public Law 99–509), the Omnibus  
 8 Budget Reconciliation Act of 1987 (Public Law 100–203),  
 9 the Omnibus Budget Reconciliation Act of 1989 (Public  
 10 Law 101–239), the Omnibus Budget Reconciliation Act  
 11 of 1990 (Public Law 101–508), and the Omnibus Budget  
 12 Reconciliation Act of 1993 (Public Law 103–66), respec-  
 13 tively.

14 (d) TABLE OF CONTENTS.—The table of contents of  
 15 this Act is as follows:

Sec. 1. Short title; amendments; references; table of contents.  
 Sec. 2. Purposes.

#### TITLE I—ESTABLISHMENT OF MEDIHEALTH PLANS

Sec. 101. MediHealth plans.  
 Sec. 102. Treatment of 1876 organizations.  
 Sec. 103. MediHealth demonstration projects.

#### TITLE II—INCREASE IN FLEXIBILITY UNDER MEDICARE

Sec. 201. Competitive bidding.  
 Sec. 202. Flexible purchasing.  
 Sec. 203. Report on use of new authorities.

#### TITLE III—QUALITY IN MEDIHEALTH PLANS

Sec. 301. Definitions.  
 Sec. 302. Quality Advisory Institute.  
 Sec. 303. Duties of Director.  
 Sec. 304. Compliance.  
 Sec. 305. Payments for value.  
 Sec. 306. Certification requirement.  
 Sec. 307. Licensing of certification entities.

Sec. 308. Certification criteria.  
Sec. 309. Grievance and appeals.

1 **SEC. 2. PURPOSES.**

2 The purposes of this Act are—

3 (1) to improve the existing medicare program  
4 under title XVIII of the Social Security Act (42  
5 U.S.C. 1395 et seq.) by adopting a competitive  
6 model to provide medicare beneficiaries with better  
7 and broader health care coverage and a greater vari-  
8 ety of health care options from which to choose;

9 (2) to increase the flexibility of the medicare  
10 program to allow health care items and services to  
11 be delivered in a progressive, efficient fashion;

12 (3) to enable the medicare program to take  
13 swift advantage of future market improvements in  
14 the means of health care delivery;

15 (4) to provide medicare beneficiaries with prac-  
16 tical information they and their families can use to  
17 make the best health care choices possible;

18 (5) to promote high quality, comprehensive, in-  
19 tegrated care geared to the needs of beneficiaries  
20 within a system that is focused on preventing and  
21 ameliorating disease;

22 (6) to encourage good health through the effi-  
23 cient delivery of care to an aging population in a va-

1       riety of settings best suited to the needs of the indi-  
 2       vidual; and

3               (7) to develop a medicare plan that will provide  
 4       quality medical care to medicare beneficiaries while  
 5       addressing the need to ensure the immediate and  
 6       long-term viability by developing a competitively  
 7       based program based on the Federal Employees  
 8       Health Benefits Plan, a proven model of health care  
 9       delivery.

## 10       **TITLE I—ESTABLISHMENT OF** 11       **MEDIHEALTH PLANS**

### 12       **SEC. 101. MEDIHEALTH PLANS.**

13       (a) IN GENERAL.—Title XVIII of the Social Security  
 14       Act (42 U.S.C. 1395 et seq.) is amended by adding at  
 15       the end the following new part:

### 16       **“PART D—MEDIHEALTH PLANS**

#### “SUBPART 1—DEFINITIONS

“Sec. 1895A. Definitions.

#### “SUBPART 2—ENTITLEMENT OF MEDIHEALTH ELIGIBLE INDIVIDUALS TO HEALTH CARE CHOICES

“Sec. 1895B. Entitlement to medicare choices.

“Sec. 1895C. Enrollment procedures.

“Sec. 1895D. Effect of enrollment.

#### “SUBPART 3—MEDIHEALTH PLAN REQUIREMENTS

“Sec. 1895G. Availability and enrollment.

“Sec. 1895H. Benefits provided to individuals.

“Sec. 1895I. Licensing and financial requirements.

“Sec. 1895J. Health plan standards.

“Sec. 1895K. MediHealth plans in rural areas.

“SUBPART 4—OFFICE OF COMPETITION; DETERMINATION OF MEDICARE  
PAYMENT AMOUNTS

“Sec. 1895M. Office of Competition.  
“Sec. 1895N. Standardized medicare payment amounts.  
“Sec. 1895O. Payments to plan sponsors.

“SUBPART 5—CONTRACTUAL AUTHORITY; TEMPORARY LICENSING;  
REGULATIONS

“Sec. 1895P. General permission to contract.  
“Sec. 1895Q. Renewal and termination of contract.  
“Sec. 1895R. Temporary licensing process for coordinated care plans.  
“Sec. 1895S. Regulations.

1 **“Subpart 1—Definitions**

2 **“SEC. 1895A. DEFINITIONS.**

3 “(a) **MEDIHEALTH PLAN.**—In this part—

4 “(1) **IN GENERAL.**—The term ‘MediHealth  
5 plan’ means an eligible health plan with respect to  
6 which there is a contract in effect under this part  
7 to provide health benefits coverage to MediHealth el-  
8 igible individuals.

9 “(2) **MEDIHEALTH PLAN SPONSOR.**—The terms  
10 ‘MediHealth plan sponsor’ and ‘plan sponsor’ mean  
11 a public or private entity which establishes or main-  
12 tains a MediHealth plan.

13 “(b) **ELIGIBLE HEALTH PLAN.**—In this part:

14 “(1) **IN GENERAL.**—The term ‘eligible health  
15 plan’ means a policy, contract, or plan which is ca-  
16 pable of providing health benefits coverage of items  
17 and services provided under the traditional medicare  
18 program to MediHealth eligible individuals.

1           “(2) TYPES OF INSURANCE.—The term ‘eligible  
2           health plan’ shall include private managed or coordi-  
3           nated care plans which provide health care services  
4           through an integrated network of providers, includ-  
5           ing—

6                   “(A) qualified health maintenance organi-  
7                   zations as defined in section 1310(d) of the  
8                   Public Health Service Act; and

9                   “(B) preferred provider organization plans,  
10                  point of service plans, provider-sponsored net-  
11                  work plans, or other coordinated care plans.

12          “(c) OTHER DEFINITIONS.—In this part:

13                  “(1) AREAS.—

14                   “(A) MEDICARE PAYMENT AREA.—

15                           “(i) IN GENERAL.—Except as pro-  
16                           vided in clause (ii), the term ‘medicare  
17                           payment area’ means—

18                                   “(I) a metropolitan statistical  
19                                   area (whether or not such area is in  
20                                   a single State) or in the case of a con-  
21                                   solidated metropolitan statistical area,  
22                                   each primary metropolitan statistical  
23                                   area within the consolidated area; or

1                   “(II) one area within each State  
2                   composed of all areas that do not fall  
3                   within a metropolitan statistical area.

4                   “(ii) GEOGRAPHIC ADJUSTMENT.—  
5                   Upon request of the chief executive officer  
6                   of a State, the Secretary may make a geo-  
7                   graphic adjustment to a medicare payment  
8                   area otherwise determined under clause (i).

9                   “(iii) AREAS.—In this subparagraph,  
10                  the terms ‘metropolitan statistical area’,  
11                  ‘consolidated metropolitan statistical area’,  
12                  and ‘primary metropolitan statistical area’  
13                  mean any area designated as such by the  
14                  Secretary of Commerce.

15                  “(B) MEDICARE SERVICE AREA.—

16                  “(i) IN GENERAL.—Except as pro-  
17                  vided in clause (ii), the term ‘medicare  
18                  service area’ means a medicare payment  
19                  area.

20                  “(ii) GEOGRAPHIC ADJUSTMENT.—  
21                  The Secretary may designate a medicare  
22                  service area other than a medicare pay-  
23                  ment area for a MediHealth plan if the  
24                  Secretary determines that such designation

1 is nondiscriminatory and consistent with  
2 the effective implementation of this part.

3 “(2) DIRECTOR.—The term ‘Director’ means  
4 the Director of the Office of Competition within the  
5 Department of Health and Human Services as es-  
6 tablished under section 1895M.

7 “(3) MEDIHEALTH ELIGIBLE INDIVIDUAL.—

8 “(A) IN GENERAL.—The term ‘MediHealth  
9 eligible individual’ means an individual who is  
10 entitled to benefits under part A and enrolled  
11 under part B.

12 “(B) SPECIAL RULE FOR END-STAGE  
13 RENAL DISEASE.—Such term shall not include  
14 an individual medically determined to have end-  
15 stage renal disease, except that an individual  
16 who develops end-stage renal disease while en-  
17 rolled in a MediHealth plan may continue to be  
18 enrolled in that plan. Not later than December  
19 31, 1999, the Secretary shall submit to the  
20 Congress recommendations on expanding the  
21 definition of ‘MediHealth eligible individual’ to  
22 include individuals with end-stage renal disease  
23 and the enrollment of such individuals in  
24 MediHealth plans.



1           “(4) TRADITIONAL MEDICARE PROGRAM.—The  
 2           term ‘traditional medicare program’ means the pro-  
 3           gram of benefits available to individuals entitled to  
 4           benefits under part A and enrolled under part B of  
 5           this title, other than enrollment in a MediHealth  
 6           plan under this part.

7           **“Subpart 2—Entitlement of MediHealth Eligible**  
 8                       **Individuals to Health Care Choices**

9           **“SEC. 1895B. ENTITLEMENT TO MEDICARE CHOICES.**

10          “Each MediHealth eligible individual is entitled to  
 11          choose to receive health care items and services covered  
 12          under parts A and B—

13               “(1) through the traditional medicare program;  
 14          or

15               “(2) by receiving payments toward the individ-  
 16          ual’s enrollment in a MediHealth plan under this  
 17          part.

18          **“SEC. 1895C. ENROLLMENT PROCEDURES.**

19          “(a) IN GENERAL.—Except as provided in section  
 20          1895G(a)(2), each MediHealth eligible individual shall be  
 21          entitled to enroll in any MediHealth plan with a medicare  
 22          service area including the geographic area in which the  
 23          individual resides during—

24               “(1) the annual open enrollment period de-  
 25          scribed in section 1895G(b)(1); or

1           “(2) any other enrollment period described in  
2           section 1895G(b)(2) applicable to the individual.

3           “(b)       METHOD       OF       ENROLLMENT       AND  
4   DISENROLLMENT.—

5           “(1) NOTICE PROVIDED TO THE SECRETARY.—

6       Each MediHealth eligible individual desiring to en-  
7       roll or terminate enrollment in a MediHealth plan  
8       shall provide the Secretary with notice of such en-  
9       rollment or disenrollment during any enrollment pe-  
10      riod applicable to the individual. The Secretary shall,  
11      to the extent feasible, provide for the receipt of such  
12      notice by telephone, through the mail, and in person  
13      at local social security offices.

14          “(2)   INFORMATION   FORWARDED   TO   THE  
15   PLAN.—The Secretary shall promptly provide each  
16   MediHealth plan with notice of an individual’s en-  
17   rollment or disenrollment with the plan.

18          “(c) NOTICES TO INDIVIDUALS TO ASSIST IN EN-  
19   ROLLMENT.—

20          “(1) OPEN SEASON NOTIFICATION.—

21               “(A) MAILING OF NOTICE.—By September  
22               30 of each year beginning after 2001, the Sec-  
23               retary shall mail a notice of eligibility to each  
24               MediHealth eligible individual and each individ-  
25               ual entitled to benefits under part A prior to

1 the end of the annual open enrollment period  
2 described in section 1895G(b)(1).

3 “(B) NOTICE DESCRIBED.—The notice de-  
4 scribed in subparagraph (A) shall include an in-  
5 formational brochure that includes the informa-  
6 tion described in this section, and any other in-  
7 formation that the Secretary determines will as-  
8 sist the individual’s enrollment decision.

9 “(2) NOTIFICATION TO NEWLY MEDIHEALTH  
10 ELIGIBLE INDIVIDUALS.—With respect to an individ-  
11 ual who becomes eligible to enroll in a MediHealth  
12 plan during the period described in section  
13 1895G(b)(2)(A) and to whom paragraph (1) does  
14 not apply, the Secretary shall, not later than 2  
15 months before the date on which the individual be-  
16 comes eligible, mail to the individual the notice of  
17 eligibility described in paragraph (1).

18 “(d) SECRETARY’S MATERIALS; CONTENTS.—The  
19 notice and informational materials mailed by the Secretary  
20 under subsection (c) shall be written and formatted in the  
21 most easily understandable manner possible, and shall in-  
22 clude, at a minimum, the following:

23 “(1) GENERAL INFORMATION.—General infor-  
24 mation with respect to coverage under this part dur-  
25 ing the next calendar year, including—

1           “(A) the part B premium rates that will be  
2 charged for part B coverage, and a statement  
3 of the fact that enrollees in MediHealth plans  
4 are not required to pay such premium,

5           “(B) the deductible, copayment, and coin-  
6 surance amounts for coverage under the tradi-  
7 tional medicare program,

8           “(C) a description of the coverage under  
9 the traditional medicare program and any  
10 changes in coverage under the program from  
11 the prior year,

12           “(D) a description of the individual’s medi-  
13 care payment area, and the standardized medi-  
14 care payment amount available with respect to  
15 such individual,

16           “(E) information and instructions on how  
17 to enroll in a MediHealth plan,

18           “(F) the right of each MediHealth plan  
19 sponsor by law to terminate or refuse to renew  
20 its contract and the effect the termination or  
21 nonrenewal of its contract may have on individ-  
22 uals enrolled with the MediHealth plan under  
23 this part,

1           “(G) appeal rights of enrollees, including  
2           the right to address grievances to the Secretary  
3           or the applicable external review entity, and

4           “(H) the benefits offered by plans in basic  
5           benefit plans under section 1895H(a), and how  
6           those benefits differ from the benefits offered  
7           under parts A and B.

8           “(2) COMPARATIVE REPORT.—A copy of the  
9           most recent comparative report (as established by  
10          the Secretary under subsection (e)) for the  
11          MediHealth plans in the individual’s medicare pay-  
12          ment area.

13          “(e) COMPARATIVE REPORT.—

14               “(1) IN GENERAL.—The Secretary shall develop  
15               an understandable standardized comparative report  
16               on the MediHealth plans offered by MediHealth plan  
17               sponsors, that will assist MediHealth eligible individ-  
18               uals in their decisionmaking regarding medical care  
19               and treatment by allowing such individuals to com-  
20               pare the MediHealth plans that such individuals are  
21               eligible to enroll with. In developing such report the  
22               Secretary shall consult with outside organizations,  
23               including groups representing the elderly,  
24               MediHealth plan sponsors, providers of services, and  
25               physicians and other health care professionals, in

1 order to assist the Secretary in developing the re-  
2 port.

3 “(2) REPORT.—The report described in para-  
4 graph (1) shall include a comparison for each  
5 MediHealth plan of—

6 “(A) the plan’s medicare service area;

7 “(B) coverage by the plan of emergency  
8 services and urgently needed care;

9 “(C) the amount of any deductibles, coin-  
10 surance, or any monetary limits on benefits;

11 “(D) the number of individuals who  
12 disenrolled from the plan within 3 months of  
13 enrollment during the previous fiscal year (ex-  
14 cluding individuals whose disenrollment was due  
15 to death or moving outside of the plan’s service  
16 area) stated as percentages of the total number  
17 of individuals in the plan;

18 “(E) process, outcome, and enrollee satis-  
19 faction measures, as recommended by the Qual-  
20 ity Advisory Institute (as established under sec-  
21 tion 302 of the Comprehensive Medicare Re-  
22 form and Improvement Act of 1997);

23 “(F) information on access and quality of  
24 services obtained from the analysis described in  
25 section 302(c)(4) of such Act;

1           “(G) the procedures used by the plan to  
2           control utilization of services and expenditures,  
3           including any financial incentives;

4           “(H) the number of applications during  
5           the previous fiscal year requesting that the plan  
6           cover or pay for certain medical services that  
7           were denied by the plan (and the number of  
8           such denials that were subsequently reversed by  
9           the plan), stated as a percentage of the total  
10          number of applications during such period re-  
11          questing that the plan cover such services;

12          “(I) the number of times during the pre-  
13          vious fiscal year (after an appeal was filed with  
14          the Secretary) that the Secretary upheld or re-  
15          versed a denial of a request that the plan cover  
16          certain medical services;

17          “(J) the restrictions (if any) on payment  
18          for services provided outside the plan’s health  
19          care provider network;

20          “(K) the process by which services may be  
21          obtained through the plan’s health care provider  
22          network;

23          “(L) coverage for out-of-area services;

1           “(M) any exclusions in the types of health  
2           care providers participating in the plan’s health  
3           care provider network;

4           “(N) whether the plan is, or has within the  
5           past two years been, out-of-compliance with any  
6           requirements of this part (as determined by the  
7           Secretary);

8           “(O) the plan’s premium price for the  
9           basic benefit plan submitted under section  
10          1895N(a)(1), an indication of the difference be-  
11          tween such premium price and the standardized  
12          medicare payment amount, and the portion of  
13          the premium an individual must pay out of  
14          pocket;

15          “(P) whether the plan offers any of the op-  
16          tional supplemental benefit plans described in  
17          section 1895H(b), and if so, the plan’s pre-  
18          mium price for the plan submitted under sec-  
19          tion 1895N(a)(1); and

20          “(Q) any additional information that the  
21          Secretary determines would be helpful for  
22          MediHealth eligible individuals to compare the  
23          MediHealth plans that such individuals are eli-  
24          gible to enroll with.



1           “(3) ADDITIONAL INFORMATION.—The com-  
2       parative report shall also include—

3           “(A) a comparison of each MediHealth  
4       plan to the fee-for-service program under parts  
5       A and B;

6           “(B) an explanation of medicare supple-  
7       mental policies under section 1882 and how to  
8       obtain specific information regarding such poli-  
9       cies; and

10          “(C) a phone number for each MediHealth  
11       plan that will enable MediHealth eligible indi-  
12       viduals to call to receive a printed listing of all  
13       health care providers participating in the plan’s  
14       health care provider network.

15          “(4) UPDATE.—The Secretary shall, not less  
16       than annually, update each comparative report.

17          “(5) DEFINITIONS.—In this subsection—

18           “(A) HEALTH CARE PROVIDER.—The term  
19       ‘health care provider’ means anyone licensed  
20       under State law to provide health care services  
21       under part A or B.

22           “(B) NETWORK.—The term ‘network’  
23       means, with respect to a MediHealth plan spon-  
24       sor, the health care providers who have entered  
25       into a contract or agreement with the plan

1 sponsor under which such providers are obli-  
 2 gated to provide items, treatment, and services  
 3 under this section to individuals enrolled with  
 4 the plan sponsor under this part.

5 “(C) OUT-OF-NETWORK.—The term ‘out-  
 6 of-network’ means services provided by health  
 7 care providers who have not entered into a con-  
 8 tract agreement with the MediHealth plan  
 9 sponsor under which such providers are obli-  
 10 gated to provide items, treatment, and services  
 11 under this section to individuals enrolled with  
 12 the plan sponsor under this part.

13 “(6) COST SHARING.—Each MediHealth plan  
 14 sponsor shall pay to the Secretary its pro rata share  
 15 of the estimated costs incurred by the Secretary in  
 16 carrying out the requirements of this section and  
 17 section 4360 of the Omnibus Reconciliation Act of  
 18 1990. There are hereby appropriated to the Sec-  
 19 retary the amount of the payments under this para-  
 20 graph for purposes of defraying the cost described in  
 21 the preceding sentence. Such amounts shall remain  
 22 available until expended.

23 “(f) AGREEMENTS WITH COMMISSIONER OF SOCIAL  
 24 SECURITY.—In order to promote the efficient administra-  
 25 tion of this section and this part, the Secretary may enter

1 into an agreement with the Commissioner of Social Secu-  
 2 rity under which the Commissioner performs administra-  
 3 tive responsibilities relating to enrollment and  
 4 disenrollment under this section.

5 **“SEC. 1895D. EFFECT OF ENROLLMENT.**

6 “(a) PREMIUM DIFFERENTIALS.—If a MediHealth  
 7 eligible individual enrolls in a MediHealth plan, the indi-  
 8 vidual shall be required to pay—

9 “(1) 10 percent of the plan’s premium;

10 “(2) if the premium of the plan is higher than  
 11 the standardized payment amount (as determined  
 12 under section 1895M), 100 percent of such dif-  
 13 ference; and

14 “(3) an amount equal to cost-sharing under the  
 15 medicare fee-for-service program, except that such  
 16 amount shall not exceed the actuarial value of the  
 17 deductibles and coinsurance under such program less  
 18 the actual value of nominal copayments for benefits  
 19 under such plan for basic benefits described in sec-  
 20 tion 1895H(a)(1).

21 “(b) PERIOD OF ENROLLMENT.—

22 “(1) ANNUAL ENROLLMENT PERIOD.—An indi-  
 23 vidual enrolling in a MediHealth plan during the an-  
 24 nual open enrollment period under section

1 1895G(b)(1) shall be enrolled in the plan for the cal-  
 2 endar year following the open enrollment period.

3 “(2) SPECIAL ENROLLMENT PERIODS.—An in-  
 4 dividual enrolling in a plan under section  
 5 1895G(b)(2) shall be enrolled in the plan for the  
 6 portion of the calender year on and after the date  
 7 on which the enrollment becomes effective (as speci-  
 8 fied by the Secretary).

9 “(3) TERMINATIONS.—

10 “(A) IN GENERAL.—Except as otherwise  
 11 provided in this subsection, an individual may  
 12 not terminate enrollment in a MediHealth plan  
 13 before the next annual open enrollment period  
 14 applicable to the individual.

15 “(B) QUALIFYING EVENTS.—Notwith-  
 16 standing subparagraph (A), an individual may  
 17 terminate enrollment in a MediHealth plan if—

18 “(i) the individual moves to a new  
 19 medicare service area, or

20 “(ii) the individual has experienced a  
 21 qualifying event (as determined by the Sec-  
 22 retary).

23 “(C) FOR CAUSE.—Notwithstanding sub-  
 24 paragraph (A), an individual may terminate en-  
 25 rollment in a MediHealth plan if the plan fails

1 to meet quality or capacity standards or for  
2 other cause as determined by the Secretary.

3 “(D) TERMINATION AFTER INITIAL EN-  
4 ROLLMENT.—An individual may terminate en-  
5 rollment in a MediHealth plan within 90 days  
6 of the individual’s initial enrollment in such  
7 MediHealth plan and enroll in another  
8 MediHealth plan or the traditional medicare  
9 program.

10 “(4) SEAMLESS ENROLLMENT.—If a  
11 MediHealth eligible individual is enrolled in a  
12 MediHealth plan under this part and such individual  
13 fails to provide the Secretary with notice of the indi-  
14 vidual’s enrollment or disenrollment under section  
15 1895C(b)(1) during any open enrollment period ap-  
16 plicable to the individual, the individual shall be  
17 deemed to have reenrolled in the plan.

18 “(c) SOLE PAYMENTS.—Subject to subsections (d)(2)  
19 and (e) of section 1895H, payments under a contract to  
20 a MediHealth plan under section 1895O shall be instead  
21 of the amounts which (in the absence of the contract)  
22 would be otherwise payable under the traditional medicare  
23 program for items or services furnished to individuals en-  
24 rolled with the plan under this section.

1       “(d) PART B PREMIUM.—An individual enrolled in  
 2 a MediHealth plan under this part shall not be required  
 3 to pay the premium amount (determined under section  
 4 1839) under part B for so long as such individual is so  
 5 enrolled.

6       **“Subpart 3—MediHealth Plan Requirements**

7       **“SEC. 1895G. AVAILABILITY AND ENROLLMENT.**

8       “(a) GENERAL AVAILABILITY.—

9               “(1) IN GENERAL.—Except as provided in para-  
 10 graph (2), each MediHealth plan sponsor shall pro-  
 11 vide that each MediHealth eligible individual shall be  
 12 eligible to enroll under this part in a MediHealth  
 13 plan of the sponsor during an enrollment period ap-  
 14 plicable to such individual if the plan’s medicare  
 15 service area includes the geographic area in which  
 16 the individual resides.

17               “(2) EXCEPTIONS.—Each MediHealth plan  
 18 sponsor shall provide that, at any time during which  
 19 enrollments are accepted, the plan sponsor will ac-  
 20 cept MediHealth eligible individuals in the order in  
 21 which they apply for enrollment up to the limits of  
 22 the MediHealth plan’s certified capacity (as deter-  
 23 mined by the Secretary) and without restrictions, ex-  
 24 cept as may be authorized in regulations. The pre-  
 25 ceding sentence shall not apply if it would result in

1 the enrollment of enrollees substantially nonrep-  
 2 resentative, as determined in accordance with regu-  
 3 lations of the Secretary, of the medicare population  
 4 in the medicare service area of the plan.

5 “(b) ENROLLMENT PERIODS.—

6 “(1) ANNUAL OPEN ENROLLMENT PERIOD.—

7 Each MediHealth plan sponsor shall offer an annual  
 8 open enrollment period in November of each year for  
 9 the enrollment and termination of enrollment of  
 10 MediHealth eligible individuals for the next year.

11 “(2) ADDITIONAL PERIODS.—Each MediHealth  
 12 plan sponsor shall accept the enrollment of an indi-  
 13 vidual in the MediHealth plan—

14 “(A) during the initial medicare enrollment  
 15 period specified by section 1837 that applies to  
 16 the individual (effective as specified by section  
 17 1838), and

18 “(B) during the period specified by the  
 19 Secretary following any termination of the en-  
 20 rollment of the individual in a MediHealth plan  
 21 under subparagraph (B), (C), or (D) of section  
 22 1895D(b)(3).

23 “(c) PLAN PARTICIPATION IN ENROLLMENT PROC-  
 24 ESS.—

1           “(1) IN GENERAL.—In addition to any informa-  
 2           tional materials distributed by the Secretary under  
 3           section 1895C(e), a MediHealth plan sponsor may  
 4           develop and distribute marketing materials and en-  
 5           gage in marketing strategies in accordance with this  
 6           subsection.

7           “(2) PLAN MARKETING AND ADVERTISING  
 8           STANDARDS.—Any marketing material developed or  
 9           distributed by a MediHealth plan sponsor and any  
 10          marketing strategy developed by such plan spon-  
 11          sor—

12                 “(A) shall accurately describe differences  
 13                 between health care coverage available under  
 14                 the plan and the health care coverage available  
 15                 under the traditional medicare program,

16                 “(B) shall be pursued in a manner not in-  
 17                 tended to violate the nondiscrimination require-  
 18                 ment of section 1895J(e)(1),

19                 “(C) shall not contain false or materially  
 20                 misleading information, and shall conform to  
 21                 any other fair marketing and advertising stand-  
 22                 ards and requirements applicable to such plans  
 23                 under law, and

24                 “(D) shall, for any written marketing ma-  
 25                 terials, contain an explanation of the



1 MediHealth eligible individual's rights and re-  
2 sponsibilities under this part and a copy of the  
3 most recent comparative report (as established  
4 by the Secretary under section 1895C) for any  
5 MediHealth plan offered by the plan sponsor in  
6 the individual's medicare payment area.

7 “(3) PRIOR APPROVAL BY SECRETARY.—

8 “(A) IN GENERAL.—No marketing mate-  
9 rials may be distributed by a MediHealth plan  
10 sponsor to (or for the use of) individuals eligible  
11 to enroll with the plan under this part unless—

12 “(i) at least 45 days before its dis-  
13 tribution, the plan has submitted the mate-  
14 rial to the Secretary for review, and

15 “(ii) the Secretary has not dis-  
16 approved the distribution of the material.

17 “(B) REVIEW.—The Secretary shall review  
18 all marketing materials submitted under guide-  
19 lines established by the Secretary and shall dis-  
20 approve such material if the Secretary deter-  
21 mines, in the Secretary's discretion, that the  
22 material is materially inaccurate or misleading  
23 or otherwise makes a material misrepresenta-  
24 tion.

1           “(C) DEEMED APPROVAL.—If marketing  
 2           material has been submitted under subpara-  
 3           graph (A) to the Secretary or a regional office  
 4           of the Department of Health and Human Serv-  
 5           ices and the Secretary or the office has not dis-  
 6           approved the distribution of the materials under  
 7           subparagraph (B) with respect to an area, the  
 8           Secretary is deemed not to have disapproved  
 9           such distribution in all areas covered by the  
 10          plan, except for information specific to the serv-  
 11          ice area.

12          “(d) RESTRICTION ON ENROLLMENT FOR CERTAIN  
 13          MEDICARE CHOICE PLANS.—

14           “(1) IN GENERAL.—In the case of a Medicare  
 15          Choice religious fraternal benefit society plan de-  
 16          scribed in paragraph (2), notwithstanding any other  
 17          provision of this part to the contrary and in accord-  
 18          ance with regulations of the Secretary, the society  
 19          offering the plan may restrict the enrollment of indi-  
 20          viduals under this part to individuals who are mem-  
 21          bers of the church, convention, or group described in  
 22          paragraph (3)(B) with which the society is affiliated.

23           “(2) MEDICAREPLUS RELIGIOUS FRATERNAL  
 24          BENEFIT SOCIETY PLAN DESCRIBED.—For purposes  
 25          of this subsection, a Medicare Choice religious fra-

1        ternal benefit society plan described in this para-  
 2        graph is a Medicare Choice plan described in section  
 3        1895A(b) that—

4                “(A) is offered by a religious fraternal ben-  
 5                efit society described in paragraph (3) only to  
 6                members of the church, convention, or group  
 7                described in paragraph (3)(B); and

8                “(B) permits all such members to enroll  
 9                under the plan without regard to health status-  
 10              related factors.

11        Nothing in this subsection shall be construed as  
 12        waiving any plan requirements relating to financial  
 13        solvency. In developing solvency standards under  
 14        section 1895I(c), the Secretary shall take into ac-  
 15        count open contract and assessment features char-  
 16        acteristic of fraternal insurance certificates.

17              “(3) RELIGIOUS FRATERNAL BENEFIT SOCIETY  
 18        DEFINED.—For purposes of paragraph (2)(A), a ‘re-  
 19        ligious fraternal benefit society’ described in this  
 20        section is an organization that—

21              “(A) is exempt from Federal income tax-  
 22              ation under section 501(c)(8) of the Internal  
 23              Revenue Code of 1986;

24              “(B) is affiliated with, carries out the te-  
 25              nets of, and shares a religious bond with, a

1 church or convention or association of churches  
 2 or an affiliated group of churches;

3 “(C) offers, in addition to a Medicare  
 4 Choice religious fraternal benefit society plan,  
 5 at least the same level of health coverage to in-  
 6 dividuals not entitled to benefits under this title  
 7 who are members of such church, convention,  
 8 or group; and

9 “(D) does not impose any limitation on  
 10 membership in the society based on any health  
 11 status-related factor.

12 “(4) PAYMENT ADJUSTMENT.—Under regula-  
 13 tions of the Secretary, in the case of individuals en-  
 14 rolled under this part under a Medicare Choice reli-  
 15 gious fraternal benefit society plan described in  
 16 paragraph (2), the Secretary shall provide for such  
 17 adjustment to the payment amounts otherwise estab-  
 18 lished under section 1895N as may be appropriate  
 19 to assure an appropriate payment level, taking into  
 20 account the actuarial characteristics and experience  
 21 of such individuals.

22 **“SEC. 1895H. BENEFITS PROVIDED TO INDIVIDUALS.**

23 “(a) BASIC BENEFIT PLAN.—Each MediHealth plan  
 24 shall provide to members enrolled under this part, through

1 providers and other persons that meet the applicable re-  
 2 quirements of this title and part A of title XI—

3 “(1) those items and services covered under  
 4 parts A and B of this title which are available to in-  
 5 dividuals residing in the medicare service area of the  
 6 plan, subject to nominal copayments as determined  
 7 by the Secretary,

8 “(2) prescription drugs, subject to such limits  
 9 as established by the Secretary, and

10 “(3) additional health services as the Secretary  
 11 may approve.

12 “(b) SUPPLEMENTAL BENEFITS.—

13 “(1) IN GENERAL.—Each MediHealth plan may  
 14 offer any of the optional supplemental benefit plans  
 15 described in paragraph (2) to an individual enrolled  
 16 in the basic benefit plan offered by such organiza-  
 17 tion under this part for an additional premium  
 18 amount. If the supplemental benefits are offered  
 19 only to individuals enrolled in the sponsor’s plan  
 20 under this part, the additional premium amount  
 21 shall be the same for all enrolled individuals in the  
 22 medicare payment area. Such benefits may be mar-  
 23 keted and sold by the MediHealth plan sponsor out-  
 24 side of the enrollment process described in section  
 25 1895D(b).

1           “(2) OPTIONAL SUPPLEMENTAL BENEFIT  
 2 PLANS DESCRIBED.—The Secretary shall provide for  
 3 2 optional supplemental benefit plans. Such plans  
 4 shall include such standardized items and services  
 5 that the Secretary determines must be provided to  
 6 enrollees of such plans described in order to offer  
 7 the plans to MediHealth eligible individuals.

8           “(3) LIMITATION.—A MediHealth plan sponsor  
 9 may not offer an optional benefit plan to a  
 10 MediHealth eligible individual unless such individual  
 11 is enrolled in a basic benefit plan offered by such or-  
 12 ganization.

13           “(4) LIMITATION ON PREMIUM.—If a  
 14 MediHealth plan sponsor provides to individuals en-  
 15 rolled in a MediHealth plan supplemental benefits  
 16 described in paragraph (1), the sum of—

17           “(A) the annual premiums for such bene-  
 18 fits, plus

19           “(B) the actuarial value of any deductibles,  
 20 coinsurance, and copayments charged with re-  
 21 spect to such benefits for the year,

22 shall not exceed the amount that would have been  
 23 charged for a plan in the MediHealth payment area  
 24 which is not a MediHealth plan (adjusted in such  
 25 manner as the Secretary may prescribe to reflect

1       that only medicare beneficiaries are enrolled in such  
2       plan). The Secretary shall negotiate the limitation  
3       under this paragraph with each plan to which this  
4       paragraph applies.

5       “(c) NATIONAL COVERAGE DETERMINATION.—If  
6       there is a national coverage determination made in the pe-  
7       riod beginning on the date of an announcement under sec-  
8       tion 1895N(b) and ending on the date of the next an-  
9       nouncement under such section and the Secretary projects  
10      that the determination will result in a significant change  
11      in the costs to the MediHealth plan of providing the bene-  
12      fits that are the subject of such national coverage deter-  
13      mination and that such change in costs was not incor-  
14      porated in the determination of the medicare payment  
15      amount included in the announcement made at the begin-  
16      ning of such period—

17           “(1) such determination shall not apply to con-  
18      tracts under this part until the first contract year  
19      that begins after the end of such period, and

20           “(2) if such coverage determination provides for  
21      coverage of additional benefits or coverage under ad-  
22      ditional circumstances, section 1895I(b)(2) shall not  
23      apply to payment for such additional benefits or  
24      benefits provided under such additional cir-

1        cumstances until the first contract year that begins  
 2        after the end of such period,  
 3 unless otherwise required by law.

4        “(d) OVERLAPPING PERIODS OF COVERAGE.—A con-  
 5 tract under this part shall provide that in the case of an  
 6 individual who is receiving inpatient hospital services from  
 7 a subsection (d) hospital (as defined in section  
 8 1886(d)(1)(B)) as of the effective date of the individ-  
 9 ual’s—

10            “(1) enrollment with a MediHealth plan under  
 11 this part—

12            “(A) payment for such services until the  
 13 date of the individual’s discharge shall be made  
 14 under this title as if the individual were not en-  
 15 rolled with the plan,

16            “(B) the plan sponsor shall not be finan-  
 17 cially responsible for payment for such services  
 18 until the date after the date of the individual’s  
 19 discharge, and

20            “(C) the plan sponsor shall nonetheless be  
 21 paid the full amount otherwise payable to the  
 22 plan under this part, or

23            “(2) termination of enrollment with a  
 24 MediHealth plan under this part—



1           “(A) the plan sponsor shall be financially  
2           responsible for payment for such services after  
3           such date and until the date of the individual’s  
4           discharge,

5           “(B) payment for such services during the  
6           stay shall not be made under section 1886(d),  
7           and

8           “(C) the plan sponsor shall not receive any  
9           payment with respect to the individual under  
10          this part during the period the individual is not  
11          enrolled.

12          “(e) ORGANIZATION AS SECONDARY PAYER.—Not-  
13          withstanding any other provision of law, a MediHealth  
14          plan sponsor may (in the case of the provision of services  
15          to an individual under this part under circumstances in  
16          which payment is made secondary pursuant to section  
17          1862(b)(2)) charge or authorize the provider of such serv-  
18          ices to charge, in accordance with the charges allowed  
19          under the law, plan, or policy which is the primary payer  
20          under such circumstances—

21               “(1) the insurance carrier, employer, or other  
22          entity which under such law, plan, or policy is to pay  
23          for the provision of such services, or

1           “(2) such individual to the extent that the indi-  
 2           vidual has been paid under such law, plan, or policy  
 3           for such services.

4   **“SEC. 1895I. LICENSING AND FINANCIAL REQUIREMENTS.**

5           “(a) LICENSING REQUIREMENT.—

6           “(1) IN GENERAL.—A MediHealth plan sponsor  
 7           shall be organized and licensed under applicable  
 8           State law as a risk-bearing entity eligible to offer  
 9           health insurance or health benefits coverage in each  
 10          State in which the MediHealth plan enrolls individ-  
 11          uals under this part.

12          “(2) COORDINATED CARE PLANS.—Paragraph  
 13          (1) shall apply to a coordinated care plan except to  
 14          the extent provided in section 1895R.

15          “(b) ASSUMPTION OF FULL FINANCIAL RISK.—A  
 16          MediHealth plan sponsor shall assume full financial risk  
 17          on a prospective basis for the provision of health care serv-  
 18          ices for which benefits are required to be provided under  
 19          paragraphs (1) and (2) of section 1895H(a)(1), except  
 20          that such plan sponsor may—

21                 “(1) obtain insurance or make other arrange-  
 22                 ments for the cost of such health care services the  
 23                 aggregate value of which exceeds \$5,000 per person  
 24                 in any year,

1           “(2) obtain insurance or make other arrange-  
 2           ments for the cost of such health care services pro-  
 3           vided to its enrolled members other than through the  
 4           plan sponsor because medical necessity required  
 5           their provision before they could be secured through  
 6           the plan sponsor,

7           “(3) obtain insurance or make other arrange-  
 8           ments for not more than 90 percent of the amount  
 9           by which its costs for any of its fiscal years exceed  
 10          115 percent of its income for such fiscal year, and

11          “(4) make arrangements with physicians or  
 12          other health professionals, health care institutions,  
 13          or any combination of such individuals or institu-  
 14          tions to assume all or part of the financial risk on  
 15          a prospective basis for the provision of basic health  
 16          services by the physicians or other health profes-  
 17          sionals or through the institutions.

18          “(c) PROTECTION AGAINST RISK OF INSOLVENCY.—

19                 “(1) IN GENERAL.—A MediHealth plan sponsor  
 20                 shall make adequate provision against the risk of in-  
 21                 solvency (including provision to prevent enrollees  
 22                 from being held liable to any person or entity for the  
 23                 plan sponsor’s debts in the event of the plan spon-  
 24                 sor’s insolvency)—

25                         “(A) as determined by the Secretary, or

1           “(B) as determined by a State which the  
 2           Secretary determines requires solvency stand-  
 3           ards at least as stringent as the standards  
 4           under subparagraph (A).

5           “(2) FACTORS TO CONSIDER.—In establishing  
 6           standards under paragraph (1) for coordinated care  
 7           plans described in section 1895A(b)(1)(B)(i), the  
 8           Secretary shall consult with interested parties and  
 9           shall take into account—

10           “(A) a coordinated care plan sponsor’s de-  
 11           livery system assets and its ability to provide  
 12           services directly to enrollees through affiliated  
 13           providers, and

14           “(B) alternative means of protecting  
 15           against insolvency, including reinsurance, unre-  
 16           stricted surplus, letters of credit, guarantees,  
 17           organizational insurance coverage, and partner-  
 18           ships with other licensed entities.

19           The Secretary is not required to include alternative  
 20           means described in subparagraph (B) in the stand-  
 21           ards but may consider such alternatives where con-  
 22           sistent with the standards.

23           “(d) PAYMENTS TO THE PLAN.—

24           “(1) PREPAID PAYMENT.—A MediHealth plan  
 25           sponsor shall be compensated (except for

1 deductibles, coinsurance, and copayments) for the  
 2 provision of health care services to individuals en-  
 3 rolled under this part by a payment by the Secretary  
 4 (and if applicable, the individual) which is paid on  
 5 a periodic basis without regard to the date the  
 6 health care services are provided and which is fixed  
 7 without regard to the frequency, extent, or kind of  
 8 health care service actually provided to a member.

9 “(2) **SOLE PAYMENTS.**—Subject to subsections  
 10 (d)(2) and (e) of section 1895H, if an individual is  
 11 enrolled under this part with a MediHealth plan,  
 12 only the plan sponsor shall be entitled to receive  
 13 payments from the Secretary under this title for  
 14 services furnished to the individual.

15 **“SEC. 1895J. HEALTH PLAN STANDARDS.**

16 “(a) **IN GENERAL.**—Each MediHealth plan sponsor  
 17 shall meet the requirements of this section.

18 “(b) **QUALITY ASSURANCE AND ACCREDITATION.**—

19 “(1) **CERTIFICATION.**—Each MediHealth plan  
 20 offered by a MediHealth plan sponsor shall be cer-  
 21 tified pursuant to title IV of the Comprehensive  
 22 Medicare Reform and Improvement Act of 1997.

23 “(2) **EXTERNAL REVIEW.**—

24 “(A) **IN GENERAL.**—Each MediHealth  
 25 plan sponsor shall, for each MediHealth plan it

operates, have an agreement with an independent quality review and improvement organization approved by the Secretary.

“(B) FUNCTIONS OF ORGANIZATION.—

Each independent quality review and improvement organization with an agreement under subparagraph (A) shall—

“(i) provide an alternative mechanism for addressing enrollee grievances,

“(ii) review plan performance based on accepted quality performance criteria,

“(iii) promote and make plans accountable for improved plan performance,

“(iv) integrate into ongoing external quality assurance activities a new set of quality indicators and standards appropriate for the medicare population that would be used to determine whether a plan is providing quality care and appropriate continuity and coordination of care, and

“(v) report to the Secretary on those plans that have demonstrated unwillingness or inability to improve their performance.

1       “(c) ACCESS.—Each MediHealth plan sponsor  
2 shall—

3               “(1) make the services described in section  
4 1895H(a) (and such other health care services as  
5 such individuals have contracted for) either directly  
6 or indirectly through providers and other persons  
7 that meet the applicable requirements of this title  
8 and part A of title XI—

9               “(A) available and accessible to each such  
10 individual, within the medicare service area of  
11 the plan, with reasonable promptness, and in a  
12 manner which assures continuity, and

13               “(B) when medically necessary, available  
14 and accessible 24 hours a day and 7 days a  
15 week,

16               “(2) provide for reimbursement with respect to  
17 such services which are provided to such an individ-  
18 ual other than through the plan’s providers, if—

19               “(A) the services were medically necessary  
20 and immediately required because of an unfore-  
21 seen illness, injury, or condition, and

22               “(B) it was not reasonable given the cir-  
23 cumstances to obtain the services through the  
24 plan’s providers,

1           “(3) provide access to appropriate providers, in-  
 2           cluding credentialed specialists, for all medically nec-  
 3           essary treatment and services, and

4           “(4) except as provided by the Secretary on a  
 5           case-by-case basis, in the case of a coordinated care  
 6           plan described in section 1895A(b)(1)(B)(i), provide  
 7           primary care services within 30 minutes or 30 miles  
 8           from an enrollee’s place of residence if the enrollee  
 9           resides in a rural area.

10          “(d) CAPACITY.—Each MediHealth plan sponsor  
 11          shall provide the Secretary with a demonstration of the  
 12          plan’s capacity to adequately service the plan’s expected  
 13          enrollment of individuals under this part.

14          “(e) CONSUMER PROTECTIONS.—

15               “(1) NONDISCRIMINATION.—Each MediHealth  
 16          plan sponsor shall provide assurances to the Sec-  
 17          retary that it will not deny enrollment to, expel, or  
 18          refuse to reenroll any such individual because of the  
 19          individual’s health status or requirements for health  
 20          care services, and that it will notify each such indi-  
 21          vidual of such fact at the time of the individual’s en-  
 22          rollment. A MediHealth plan sponsor may not cancel  
 23          or refuse to renew a beneficiary except in the case  
 24          of fraud or nonpayment of premium amounts due



the plan, or other circumstances specified by the Secretary.

“(2) GRIEVANCE PROCEDURES.—

“(A) IN GENERAL.—Each MediHealth plan sponsor shall provide meaningful procedures for hearing and resolving grievances between the plan (including any entity or individual through which the plan provides health care services) and members enrolled with the plan under this part.

“(B) COVERAGE DETERMINATIONS AND APPEALS.—

“(i) DETERMINATION BY ORGANIZATION.—A MediHealth plan sponsor shall have a procedure for determining whether an individual enrolled with the organization under this part is entitled to receive a benefit described in section 1851H and the amount (if any) that the individual is required to pay for that benefit, which includes the following elements:

“(I) RECONSIDERATION.—The organization shall provide for reconsideration of an initial adverse determination.

1                   “(II) EXPEDITED DETERMINA-  
2                   TIONS IN URGENT CASES.—The orga-  
3                   nization shall have an expedited proc-  
4                   ess for determinations and reconsider-  
5                   ations in cases in which delayed treat-  
6                   ment could seriously jeopardize the  
7                   life or health of the individual, or the  
8                   individual’s ability to regain maximum  
9                   function.

10                  “(III) TIME LIMITS.—The Sec-  
11                  retary may establish time limitations  
12                  for determinations and reconsider-  
13                  ations under this clause.

14                  “(ii) REVIEW BY EXTERNAL CON-  
15                  TRACTOR.—The Secretary shall establish  
16                  procedures for the independent review of  
17                  reconsiderations under clause (i) that are  
18                  adverse to the individual.

19                  “(iii) APPEAL TO SECRETARY.—An  
20                  individual dissatisfied with a determination  
21                  under clause (ii) concerning the individ-  
22                  ual’s coverage under a plan under this part  
23                  is entitled, if the amount in controversy is  
24                  \$100 or more, to a hearing before the Sec-  
25                  retary to the same extent as is provided in

1 section 205(b), and in such a hearing the  
 2 Secretary shall make the MediHealth plan  
 3 sponsor a party. If the amount in con-  
 4 troversy is \$1,000 or more, the individual  
 5 or sponsor, upon notifying the other party,  
 6 shall be entitled to judicial review of the  
 7 Secretary's final decision as provided in  
 8 section 205(g), and both the individual and  
 9 the sponsor shall be entitled to be parties  
 10 to that judicial review. In applying sections  
 11 205(b) and 205(g) as provided in this  
 12 paragraph, and in applying section 205(l)  
 13 thereto, any reference to the Commissioner  
 14 of Social Security or the Social Security  
 15 Administration shall be considered a ref-  
 16 erence to the Secretary or the Department  
 17 of Health and Human Services, respec-  
 18 tively.

19 “(3) SUPPLEMENTAL COVERAGE IF PLAN TER-  
 20 MINATES THE CONTRACT.—Each MediHealth plan  
 21 sponsor that provides items and services pursuant to  
 22 a contract under this part shall provide assurances  
 23 to the Secretary that in the event the contract is ter-  
 24 minated, the sponsor shall provide or arrange for  
 25 supplemental coverage of benefits under this title re-

1       lated to a preexisting condition with respect to any  
 2       exclusion period, to all individuals enrolled with the  
 3       entity who receive benefits under this title, for the  
 4       lesser of 6 months or the duration of such period.

5       “(f) PROMPT PAYMENT.—

6               “(1) IN GENERAL.—Each MediHealth plan  
 7       sponsor shall provide prompt payment (consistent  
 8       with the provisions of sections 1816(c)(2) and  
 9       1842(c)(2)) of claims submitted for services and  
 10      supplies furnished to individuals pursuant to such  
 11      contract, if the services or supplies are not furnished  
 12      under a contract between the plan and the provider  
 13      or supplier.

14             “(2) DIRECT PAYMENT.—In the case of a  
 15      MediHealth plan sponsor which the Secretary deter-  
 16      mines, after notice and opportunity for a hearing,  
 17      has failed to make payments of amounts in compli-  
 18      ance with paragraph (1), the Secretary may provide  
 19      for direct payment of the amounts owed to providers  
 20      and suppliers for such covered services furnished to  
 21      individuals enrolled under this part under the con-  
 22      tract. If the Secretary provides for such direct pay-  
 23      ments, the Secretary shall provide for an appropriate  
 24      reduction in the amount of payments otherwise  
 25      made to the plan sponsor under this part to reflect

1 the amount of the Secretary's payments (and costs  
 2 incurred by the Secretary in making such pay-  
 3 ments).

4 “(g) MINIMUM PRIVATE ENROLLMENT.—The  
 5 MediHealth plan sponsor shall have at least 5,000 enroll-  
 6 ees that are not eligible for benefits under this title or  
 7 under title XIX, except that the Secretary may waive such  
 8 requirement—

9 “(1) if the MediHealth plan sponsor primarily  
 10 serves enrollees residing outside urban areas; or

11 “(2) in situations and under conditions that the  
 12 Secretary determines are in the best interest of indi-  
 13 viduals entitled to benefits under this title.

14 **“SEC. 1895K. MEDIHEALTH PLANS IN RURAL AREAS.**

15 “(a) IN GENERAL.—The Secretary may waive or  
 16 modify any requirement of a MediHealth plan under this  
 17 part for a MediHealth plan that is offered in a rural area  
 18 (as defined in section 1886(d)(2)(D)) to—

19 “(1) reflect any differences between the provi-  
 20 sion of health care items and services in rural and  
 21 nonrural areas; and

22 “(2) encourage organizations to offer  
 23 MediHealth plans in rural areas.

24 “(b) QUALITY.—If the Secretary waives or modifies  
 25 any requirement of a MediHealth plan pursuant to sub-

1 section (a), the Secretary shall ensure that such waiver  
 2 or modification does not undermine the quality of the  
 3 health care items and services provided under such plan.

4 **“Subpart 4—Office of Competition; Determination of**  
 5 **Medicare Payment Amounts**

6 **“SEC. 1895M. OFFICE OF COMPETITION.**

7 “(a) ESTABLISHMENT.—There is established within  
 8 the Department of Health and Human Services an office  
 9 to be known as the ‘Office of Competition’.

10 “(b) DIRECTOR.—The Secretary shall appoint the  
 11 Director of the Office of Competition.

12 “(c) DUTIES.—

13 “(1) IN GENERAL.—The Director shall admin-  
 14 ister this part and section 1876.

15 “(2) TRANSFER AUTHORITY.—The Secretary  
 16 shall transfer such personnel, administrative support  
 17 systems, assets, records, funds, and other resources  
 18 in the Health Care Financing Administration to the  
 19 Office of Competition as are used in the administra-  
 20 tion of section 1876 and as may be required to im-  
 21 plement the provisions of this part promptly and ef-  
 22 ficiently.

23 “(d) USE OF NON-FEDERAL ENTITIES.—The Sec-  
 24 retary shall, to the maximum extent feasible, enter into

1 contracts with appropriate non-Federal entities to carry  
 2 out activities under this part.

3 **“SEC. 1895N. STANDARDIZED MEDICARE PAYMENT**  
 4 **AMOUNTS.**

5 “(a) SUBMISSION AND CHARGING OF PREMIUMS.—

6 “(1) IN GENERAL.—Not later than June 1 of  
 7 each calendar year, each MediHealth plan sponsor  
 8 shall file with the Secretary, in a form and manner  
 9 and at a time specified by the Secretary, a bid which  
 10 contains the amount of the monthly premium for  
 11 coverage under each MediHealth plan it offers under  
 12 this part in each medicare payment area in which  
 13 the plan is being offered.

14 “(2) UNIFORM PREMIUM.—The premiums  
 15 charged by a MediHealth plan sponsor under this  
 16 part may not vary among individuals who reside in  
 17 the same medicare payment area.

18 “(3) TERMS AND CONDITIONS OF IMPOSING  
 19 PREMIUMS.—Each MediHealth plan sponsor shall  
 20 permit the payment of premiums on a monthly  
 21 basis.

22 “(b) ANNOUNCEMENT OF STANDARDIZED MEDICARE  
 23 PAYMENT AMOUNTS.—

24 “(1) AUTHORITY TO NEGOTIATE.—After bids  
 25 are submitted under subsection (a), the Secretary

1       may negotiate with MediHealth plan sponsors in  
 2       order to modify such bids if the Secretary deter-  
 3       mined that the bids do not provide enough revenues  
 4       to ensure the plan’s actuarial soundness, are too  
 5       high relative to the medicare payment area, foster  
 6       adverse selection, or otherwise require renegotiation  
 7       under this paragraph.

8               “(2) IN GENERAL.—Not later than July 31 of  
 9       each calendar year (beginning with 2002), the Sec-  
 10      retary shall determine, and announce in a manner  
 11      intended to provide notice to interested parties, a  
 12      standardized medicare payment amount determined  
 13      in accordance with this section for the following cal-  
 14      endar year for each medicare payment area.

15      “(c) CALCULATION OF STANDARDIZED MEDICARE  
 16      PAYMENT AMOUNTS.—

17              “(1) IN GENERAL.—The standardized medicare  
 18      payment amount for a calendar year after 2002 for  
 19      any medicare payment area shall be equal to the  
 20      maximum premium determined for such area under  
 21      paragraph (2).

22              “(2) MAXIMUM PREMIUM.—The maximum pre-  
 23      mium for any medicare payment area shall be equal  
 24      to the amount determined under paragraph (3) for



1 the payment area, but in no case shall such amount  
 2 be greater than the sum of—

3 “(A) the average per capita amount, as de-  
 4 termined by the Secretary as appropriate for  
 5 the population eligible to enroll in MediHealth  
 6 plans in such payment area, for such calendar  
 7 year that the Secretary would have expended  
 8 for an individual in such payment area enrolled  
 9 under the medicare fee-for-service program  
 10 under parts A and B, plus

11 “(B) the amount equal to the actuarial  
 12 value of deductibles, coinsurance, and copay-  
 13 ments charged an individual for services pro-  
 14 vided under the medicare fee-for-service pro-  
 15 gram (as determined by the Secretary).

16 “(3) DETERMINATION OF AMOUNT.—

17 “(A) IN GENERAL.—The Secretary shall  
 18 determine for each medicare payment area for  
 19 each calendar year an amount equal to the av-  
 20 erage of the bids (weighted based on capacity)  
 21 submitted to the Secretary under subsection  
 22 (a)(1) for that payment area.

23 “(B) DISREGARD CERTAIN PLANS.—In de-  
 24 termining the amount under subparagraph (A),  
 25 the Secretary may disregard any plan that the

1 Director determines would unreasonably distort  
 2 the amount determined under such subpara-  
 3 graph.

4 “(d) ADJUSTMENTS FOR PAYMENTS TO PLAN SPON-  
 5 SORS.—

6 “(1) IN GENERAL.—For purposes of determin-  
 7 ing the amount of payment under section 1895O to  
 8 a MediHealth plan sponsor with respect to any  
 9 MediHealth eligible individual enrolled in a  
 10 MediHealth plan of the sponsor, the standardized  
 11 medicare payment amount for the medicare payment  
 12 area and the premium charged by the plan sponsor  
 13 shall be adjusted with respect to such individual for  
 14 such risk factors as age, disability status, gender, in-  
 15 stitutional status, health status, and such other fac-  
 16 tors as the Secretary determines to be appropriate,  
 17 so as to ensure actuarial equivalence. The Secretary  
 18 may add to, modify, or substitute for such classes,  
 19 if such changes will improve the determination of ac-  
 20 tuarial equivalence.

21 “(2) RECOMMENDATIONS.—

22 “(A) IN GENERAL.—In addition to any  
 23 other duties required by law, the Physician  
 24 Payment Review Commission and the Prospec-

tive Payment Assessment Commission shall  
each develop recommendations on—

“(i) the risk factors that the Secretary  
should use in adjusting the standardized  
medicare payment amount and premium  
under paragraph (1), and

“(ii) the methodology that the Sec-  
retary should use in determining the risk  
factors to be used in adjusting the stand-  
ardized medicare payment amount and  
premium under paragraph (1).

“(B) TIME.—The recommendations de-  
scribed in subparagraph (A) shall be developed  
not later than January 1, 1999.

“(C) ANNUAL REPORT.—The Physician  
Payment Review Commission and the Prospec-  
tive Payment Assessment Commission shall in-  
clude the recommendations described in sub-  
paragraph (A) in their respective annual re-  
ports to Congress.

**“SEC. 1895O. PAYMENTS TO PLAN SPONSORS.**

“(a) MONTHLY PAYMENTS.—

“(1) IN GENERAL.—Subject to subsection (d),  
for each individual enrolled with a plan under this  
part, the Secretary shall make monthly payments in

1 advance to the MediHealth plan sponsor of the  
 2 MediHealth plan with which the individual is en-  
 3 rolled in an amount equal to  $\frac{1}{12}$  of the amount de-  
 4 termined under subsection (b).

5 “(2) RETROACTIVE ADJUSTMENTS.—The  
 6 amount of payment under this paragraph may be  
 7 retroactively adjusted to take into account any dif-  
 8 ference between the actual number of individuals en-  
 9 rolled in the plan under this section and the number  
 10 of such individuals estimated to be so enrolled in de-  
 11 termining the amount of the advance payment.

12 “(b) AMOUNT OF PAYMENT TO MEDIHEALTH  
 13 PLANS.—The amount determined under this subsection  
 14 with respect to any individual shall be equal to the sum  
 15 of—

16 “(1) the lesser of—

17 “(A) the standardized medicare payment  
 18 amount for the medicare payment area, as ad-  
 19 justed for such individual under section  
 20 1895N(d), or

21 “(B) the premium charged by the plan for  
 22 such individual, as adjusted for such individual  
 23 under section 1895N(d), minus

1           “(2) the amount such individual paid to the  
2           plan pursuant to section 1895D(a)(1) (relating to 10  
3           percent of the premium).

4           “(c) PAYMENTS FROM TRUST FUNDS.—The pay-  
5           ment to a MediHealth plan sponsor or to a MediHealth  
6           account under this section for a medicare-eligible individ-  
7           ual shall be made from the Federal Hospital Insurance  
8           Trust Fund and the Federal Supplementary Medical In-  
9           surance Trust Fund in such proportion as the Secretary  
10          determines reflects the relative weight that benefits under  
11          parts A and B are representative of the actuarial value  
12          of the total benefits under this part.

13          “(d) LIMITATION ON AMOUNTS AN OUT-OF-PLAN  
14          PHYSICIAN OR OTHER ENTITY MAY COLLECT.—

15               “(1) IN GENERAL.—A physician or other entity  
16               (other than a provider of services) that does not  
17               have a contract establishing payment amounts for  
18               services furnished to an individual enrolled under  
19               this part with an eligible organization shall accept as  
20               payment in full for services that are furnished to  
21               such an individual the amounts that the physician or  
22               other entity could collect if the individual were not  
23               so enrolled. Any penalty or other provision of law  
24               that applies to such a payment with respect to an  
25               individual entitled to benefits under this title (but

1 not enrolled with an eligible organization under this  
 2 part) also applies with respect to an individual so  
 3 enrolled.

4 “(2) CROSS REFERENCE.—For similar require-  
 5 ments applicable to providers of services, see section  
 6 1866(a)(1)(O).

7 **“Subpart 5—Contractual Authority; Temporary**  
 8 **Licensing; Regulations**

9 **“SEC. 1895P. GENERAL PERMISSION TO CONTRACT.**

10 “The Secretary shall enter into a contract with any  
 11 MediHealth plan sponsor in a medicare payment area if  
 12 the requirements of this part are met with respect to the  
 13 MediHealth plan and the plan sponsor.

14 **“SEC. 1895Q. RENEWAL AND TERMINATION OF CONTRACT.**

15 “(a) IN GENERAL.—Except as provided in subsection  
 16 (b), each contract under this part may be made automati-  
 17 cally renewable from term to term in the absence of notice  
 18 by either party of intention to terminate at the end of the  
 19 current term.

20 “(b) TERMINATION FOR CAUSE.—

21 “(1) IN GENERAL.—In accordance with proce-  
 22 dures established under paragraph (2), the Secretary  
 23 may terminate any contact with a MediHealth plan  
 24 sponsor at any time or may impose the intermediate  
 25 sanctions described in paragraph (2) or (3) or sub-

1 section (f) (whichever is applicable) on the plan  
 2 sponsor, if the Secretary finds that the plan spon-  
 3 sor—

4 “(A) has failed substantially to carry out  
 5 the contract,

6 “(B) is carrying out the contract in a man-  
 7 ner substantially inconsistent with the efficient  
 8 and effective administration of this part, or

9 “(C) no longer substantially meets the ap-  
 10 plicable conditions of this part.

11 “(2) PROCEDURES.—The Secretary may termi-  
 12 nate a contract with a MediHealth plan sponsor  
 13 under this part in accordance with formal investiga-  
 14 tion and compliance procedures established by the  
 15 Secretary under which—

16 “(A) the Secretary first provides the  
 17 MediHealth plan sponsor with the reasonable  
 18 opportunity to develop and implement a correc-  
 19 tive action plan to correct the deficiencies that  
 20 were the basis of the Secretary’s determination  
 21 under paragraph (1) and the MediHealth plan  
 22 sponsor fails to develop or implement such a  
 23 corrective action plan, and

24 “(B) the Secretary provides the plan spon-  
 25 sor with reasonable notice and opportunity for

1           hearing (including the right to appeal an initial  
2           decision) before imposing any sanction or termi-  
3           nating the contract.

4           “(c) TERMS OF CONTRACT.—Each contract under  
5 this part shall—

6           “(1) provide that the Secretary, or any person  
7           or organization designated by the Secretary—

8           “(A) shall have the right to inspect or oth-  
9           erwise evaluate—

10           “(i) the quality, appropriateness, and  
11           timeliness of services performed under the  
12           contract, and

13           “(ii) the facilities of the plan sponsor  
14           when there is reasonable evidence of some  
15           need for such inspection,

16           “(B) shall have the right to audit and in-  
17           spect any books and records of the plan sponsor  
18           that pertain to the ability of the plan sponsor  
19           to bear the risk of potential financial losses,

20           “(2) require the plan sponsor with a contract to  
21           provide (and pay for) written notice in advance of  
22           the contract’s termination, as well as a description  
23           of alternatives for obtaining benefits under this title,  
24           to each individual enrolled under this part with the  
25           plan sponsor,



1           “(3) except as provided by the Secretary, re-  
2       quire the plan sponsor to comply with requirements  
3       similar to the requirements of subsections (a) and  
4       (c) of section 1318 of the Public Health Service Act  
5       (relating to disclosure of certain financial informa-  
6       tion) and section 1301(c)(8) of such Act (relating to  
7       liability arrangements to protect members),

8           “(4) require the plan sponsor to provide and  
9       supply information (described in section  
10      1866(b)(2)(C)(ii)) in the manner such information is  
11      required to be provided or supplied under that sec-  
12      tion,

13          “(5) require the plan sponsor to notify the Sec-  
14      retary of loans and other special financial arrange-  
15      ments which are made between the plan sponsor and  
16      subcontractors, affiliates, and related parties, and

17          “(6) contain such other terms and conditions  
18      not inconsistent with this part (including requiring  
19      the plan sponsor to provide the Secretary with such  
20      information) as the Secretary may find necessary  
21      and appropriate.

22          “(d) 5-YEAR LOCKOUT.—The Secretary may not  
23      enter into a contract under this part with a MediHealth  
24      plan sponsor if a previous contract with that plan sponsor  
25      under this part was terminated at the request of the plan

1 sponsor within the preceding 5-year period, except in cir-  
 2 cumstances which warrant special consideration, as deter-  
 3 mined by the Secretary.

4 “(e) APPLICATION OF OTHER FEDERAL LAWS.—The  
 5 authority vested in the Secretary by this part may be per-  
 6 formed without regard to such provisions of law or regula-  
 7 tions relating to the making, performance, amendment, or  
 8 modification of contracts of the United States as the Sec-  
 9 retary may determine to be inconsistent with the further-  
 10 ance of the purpose of this title.

11 “(f) REMEDIES FOR FAILURE TO COMPLY.—

12 “(1) FAILURE OF PLAN SPONSOR TO COMPLY  
 13 WITH CONTRACT.—If the Secretary determines that  
 14 a MediHealth plan sponsor—

15 “(A) fails substantially to provide medi-  
 16 cally necessary items and services that are re-  
 17 quired (under law or under the contract) to be  
 18 provided to an individual covered under the con-  
 19 tract, and the failure has adversely affected (or  
 20 has substantial likelihood of adversely affecting)  
 21 the individual,

22 “(B) imposes cost-sharing on individuals  
 23 enrolled under this part in excess of the cost-  
 24 sharing permitted,

1           “(C) acts to expel or to refuse to reenroll  
2           an individual in violation of the provisions of  
3           this part,

4           “(D) engages in any practice that would  
5           reasonably be expected to have the effect of de-  
6           nying or discouraging enrollment (except as  
7           permitted by this part) by eligible individuals  
8           with the plan whose medical condition or his-  
9           tory indicates a need for substantial future  
10          medical services,

11          “(E) misrepresents or falsifies information  
12          that is furnished—

13                 “(i) to the Secretary under this sec-  
14                 tion, or

15                 “(ii) to an individual or to any other  
16                 entity under this section,

17          “(F) fails to comply with the requirements  
18          of section 1895J(f), or

19          “(G) employs or contracts with any indi-  
20          vidual or entity that is excluded from participa-  
21          tion under this title under section 1128 or  
22          1128A for the provision of health care, utiliza-  
23          tion review, medical social work, or administra-  
24          tive services or employs or contracts with any  
25          entity for the provision (directly or indirectly)

1 through such an excluded individual or entity of  
2 such services,  
3 the Secretary may provide, in addition to any other  
4 remedies authorized by law, for any of the remedies  
5 described in paragraph (2).

6 “(2) REMEDIES.—The remedies described in  
7 this paragraph are—

8 “(A) civil money penalties of not more  
9 than \$25,000 for each determination under  
10 paragraph (1) or, with respect to a determina-  
11 tion under subparagraph (D) or (E)(i) of such  
12 paragraph, of not more than \$100,000 for each  
13 such determination, plus, with respect to a de-  
14 termination under paragraph (1)(B), double the  
15 excess amount charged in violation of such sub-  
16 paragraph (and the excess amount charged  
17 shall be deducted from the penalty and returned  
18 to the individual concerned), and plus, with re-  
19 spect to a determination under paragraph  
20 (1)(D), \$15,000 for each individual not enrolled  
21 as a result of the practice involved,

22 “(B) suspension of enrollment of individ-  
23 uals under this section after the date the Sec-  
24 retary notifies the plan sponsor of a determina-  
25 tion under paragraph (1) and until the Sec-

1           retary is satisfied that the basis for such deter-  
2           mination has been corrected and is not likely to  
3           recur, or

4           “(C) suspension of payment to the plan  
5           sponsor under this section for individuals en-  
6           rolled after the date the Secretary notifies the  
7           plan sponsor of a determination under para-  
8           graph (1) and until the Secretary is satisfied  
9           that the basis for such determination has been  
10          corrected and is not likely to recur.

11          “(3) INTERMEDIATE SANCTIONS.—In the case  
12          of a MediHealth plan sponsor for which the Sec-  
13          retary makes a determination under subsection  
14          (b)(1) the basis of which is not described in subpara-  
15          graph (A) thereof, the Secretary may apply the fol-  
16          lowing intermediate sanctions:

17               “(A) Civil money penalties of not more  
18               than \$25,000 for each determination under  
19               subsection (b)(1) if the deficiency that is the  
20               basis of the determination has directly adversely  
21               affected (or has the substantial likelihood of ad-  
22               versely affecting) an individual covered under  
23               the plan’s contract.

24               “(B) Civil money penalties of not more  
25               than \$10,000 for each week beginning after the

1 initiation of procedures by the Secretary under  
 2 subsection (b)(2) during which the deficiency  
 3 that is the basis of a determination under sub-  
 4 section (b)(1) exists.

5 “(C) Suspension of enrollment of individ-  
 6 uals under this section after the date the Sec-  
 7 retary notifies the plan sponsor of a determina-  
 8 tion under subsection (b)(1) and until the Sec-  
 9 retary is satisfied that the deficiency that is the  
 10 basis for the determination has been corrected  
 11 and is not likely to recur.

12 “(4) PROCEEDINGS.—The provisions of section  
 13 1128A (other than subsections (a), (b), and (m))  
 14 shall apply to a civil money penalty under paragraph  
 15 (2)(A) or (3)(A) in the same manner as they apply  
 16 to a civil money penalty or proceeding under section  
 17 1128A(a).

18 **“SEC. 1895R. TEMPORARY LICENSING PROCESS FOR CO-**  
 19 **ORDINATED CARE PLANS.**

20 “(a) FEDERAL ACTION ON LICENSING.—

21 “(1) IN GENERAL.—If—

22 “(A) a State fails to substantially complete  
 23 action on a licensing application of a coordi-  
 24 nated care plan sponsor within 120 days of re-  
 25 ceipt of the completed application, or

1           “(B) a State denies a licensing application  
 2           and the Secretary determines that the State’s  
 3           licensing standards or review process create an  
 4           unreasonable barrier to market entry,  
 5           the Secretary shall evaluate such application pursu-  
 6           ant to the procedures established under subsection  
 7           (b).

8           “(2) UNREASONABLE BARRIERS TO MARKET  
 9           ENTRY.—A State’s licensing standards and review  
 10          process shall not be treated as unreasonable barriers  
 11          to market entry under paragraph (1) if they—

12           “(A) are applied on a nondiscriminatory  
 13           basis to all coordinated care MediHealth plan  
 14           applications, and

15           “(B) are not directly in conflict, or incon-  
 16           sistent with, the Federal standards.

17          “(b) FEDERAL LICENSING PROCEDURES.—

18           “(1) IN GENERAL.—The Secretary shall estab-  
 19           lish a process for the licensing of a coordinated care  
 20           plan and its sponsor as meeting the requirements of  
 21           this part in cases described in subsection (a)(1).

22           “(2) REQUIREMENTS.—Such process shall—

23           “(A) set forth the standards for the licens-  
 24           ing,

1           “(B) provide that final action will be taken  
2           on an application for licensing within 120 busi-  
3           ness days of receipt of the completed applica-  
4           tion,

5           “(C) provide that State law and regula-  
6           tions shall apply to the extent they have not  
7           been found to be an unreasonable barrier to  
8           market entry under subsection (a)(1)(B), and

9           “(D) require any person receiving a license  
10          to provide the Secretary with all reasonable in-  
11          formation in order to ensure compliance with  
12          the licensing.

13          “(3) EFFECT OF LICENSING.—

14               “(A) IN GENERAL.—A license under this  
15          section shall be issued for not more than 36  
16          months and may not be renewed.

17               “(B) COORDINATION WITH STATE.—A per-  
18          son receiving a license under this section shall  
19          continue to seek State licensure under sub-  
20          section (a) during the period the license is in ef-  
21          fect.

22               “(C) SUNSET.—No license shall be issued  
23          under this section after December 31, 2006,  
24          and no license under this section shall remain  
25          in effect after December 31, 2007.



1       “(c) REPORT.—Not later than December 31, 2004,  
 2 the Secretary shall report to Congress on the temporary  
 3 Federal licensing system under subsection (b), including  
 4 an analysis of State efforts to adopt licensing standards  
 5 and review processes that take into account the fact that  
 6 coordinated care plan sponsors provide services directly to  
 7 enrollees through affiliated providers.

8       “(d) COORDINATED CARE PLAN.—In this section,  
 9 the term ‘coordinated care plan’ means a plan described  
 10 in section 1895A(b)(1)(B)(i).

11       “(e) TRANSITION RULE FOR CERTAIN RISK CON-  
 12 TRACTORS.—A MediHealth plan sponsor that is an eligible  
 13 organization (as defined in section 1876(b)) and that—

14               “(1) has a risk-sharing contract in effect under  
 15       section 1876 as of the date of enactment of this  
 16       part, or

17               “(2) has an application for such a contract filed  
 18       before such date and the contract is entered into be-  
 19       fore July 1, 2002,

20 shall be treated as meeting the Federal standards in effect  
 21 under this section for any contract year beginning before  
 22 January 1, 2006.

23 **“SEC. 1895S. REGULATIONS.**

24       “(a) IN GENERAL.—The Secretary shall establish  
 25 such regulations as may be necessary to carry out the pur-

1 poses of this part, including regulations setting forth the  
 2 requirements to meet all quality, access, and solvency  
 3 standards specified in sections 1895I and 1895J.

4 “(b) USE OF INTERIM, FINAL REGULATIONS.—In  
 5 order to carry out the provisions of this part in a timely  
 6 manner, the Secretary may, within 120 days after the date  
 7 of enactment of this part, promulgate regulations de-  
 8 scribed in subsection (a) that take effect on an interim  
 9 basis, after notice and opportunity for public comment.”.

10 (b) CONFORMING AMENDMENTS.—

11 (1) IN GENERAL.—Not later than 90 days after  
 12 the date of enactment of this Act, the Secretary of  
 13 Health and Human Services shall submit to the ap-  
 14 propriate committees of Congress a legislative pro-  
 15 posal providing for such technical and conforming  
 16 amendments in the law as are required by the provi-  
 17 sions of this chapter.

18 (2) OTHER AMENDMENTS.—(A) Section  
 19 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is  
 20 amended—

21 (i) in the matter preceding clause (i), by  
 22 inserting “or MediHealth plan under part D”  
 23 after “eligible organization”, and

24 (ii) in clause (i), by inserting “or under a  
 25 contract under part D,” after “1972,”.

1           (B)     Section     1882(g)(1)     (42     U.S.C.  
2     1395ww(g)(1)) is amended in the first sentence by  
3     inserting “, or under a MediHealth plan under part  
4     D” before the end period.

5           (C) Section 1839 (42 U.S.C. 1395r) is amended  
6     by adding at the end the following:

7     “(h) An individual enrolled in a MediHealth plan  
8     under part D shall not be required to pay the premium  
9     (determined under this section) under this part for so long  
10    as the individual is so enrolled.”.

11       (c) EFFECTIVE DATE.—The amendments made by  
12    this section shall apply with respect to contracts effective  
13    on and after January 1, 2003.

14    **SEC. 102. TREATMENT OF 1876 ORGANIZATIONS.**

15       Section 1876 (42 U.S.C. 1395mm) is amended by  
16    adding at the end the following new subsection:

17       “(k)(1) Except as provided in paragraph (2), this sec-  
18    tion shall not apply to risk-sharing contracts effective for  
19    contract years beginning on or after January 1, 2003.

20       “(2) An individual who is enrolled in part B only and  
21    is enrolled in an eligible organization with a risk-sharing  
22    contract under this section on December 31, 2002, may  
23    continue enrollment in such organization. Not later than  
24    July 1, 2002, the Secretary shall issue regulations relating  
25    to such individuals and such organizations.”.

1 **SEC. 103. MEDIHEALTH DEMONSTRATION PROJECTS.**

2 (a) DEMONSTRATION PROJECTS.—

3 (1) IN GENERAL.—The Secretary shall conduct  
4 demonstration projects in applicable areas, as de-  
5 fined in paragraph (2), for the purpose of conduct-  
6 ing a demonstration project as described in para-  
7 graph (3). Such projects shall provide for payments  
8 under the projects to begin on January 1, 1999.

9 (2) APPLICABLE AREA DEFINED.—In para-  
10 graph (1), the term “applicable area” means, as de-  
11 termined by the Secretary of Health and Human  
12 Services—

13 (A) 10 urban areas with respect to which  
14 less than 25 percent of medicare beneficiaries  
15 are enrolled with an eligible organization under  
16 section 1876 of the Social Security Act (42  
17 U.S.C. 1395mm); and

18 (B) 3 rural areas not described in subpara-  
19 graph (A).

20 (3) DEMONSTRATION PROJECT.—A demonstra-  
21 tion project described in this paragraph is a dem-  
22 onstration project that implements the amendments  
23 made to title XVIII of the Social Security Act (42  
24 U.S.C. 1395 et seq.) by this Act, as if such amend-  
25 ments had become effective on the date of enactment  
26 of this Act.

1 (b) REPORT TO CONGRESS.—

2 (1) IN GENERAL.—Not later than December 31,  
3 2000, the Secretary shall submit to the President a  
4 report regarding the demonstration projects con-  
5 ducted under this section.

6 (2) CONTENTS OF REPORT.—The report de-  
7 scribed in paragraph (1) shall include the following:

8 (A) A description of the demonstration  
9 projects conducted under this section.

10 (B) An evaluation of the effectiveness of  
11 the demonstration projects conducted under  
12 this section and any legislative recommenda-  
13 tions determined appropriate by the Secretary.

14 (C) Any other information regarding the  
15 demonstration projects conducted under this  
16 section that the Secretary determines to be ap-  
17 propriate.

18 (D) An evaluation as to whether the meth-  
19 od of payment under section 1895N of the So-  
20 cial Security Act (as added by section 101)  
21 which was used in the demonstration projects  
22 for payment to MediHealth plans should be ex-  
23 tended to the entire medicare population and if  
24 such evaluation determines that such method  
25 should not be extended, legislative recommenda-

1           tions to modify such method so that it may be  
2           applied to the entire medicare population.

3           (3) SUBMISSION TO CONGRESS.—The President  
4           shall submit the report under paragraph (2) to the  
5           Congress and if the President determines appro-  
6           priate, an implementing bill with respect to any leg-  
7           islative recommendations under paragraph (2) (B)  
8           or (D).

9           (4) EXPEDITED CONGRESSIONAL CONSIDER-  
10          ATION OF LEGISLATION.—

11           (A) IN GENERAL.—An implementing bill  
12          submitted under paragraph (3) shall—

13                   (i) not later than 3 days after it is  
14                   submitted, be introduced (by request) in  
15                   the House of Representatives by the Ma-  
16                   jority Leader of the House and shall be in-  
17                   troduced (by request) in the Senate by the  
18                   Majority Leader of the Senate; and

19                   (ii) be given expedited consideration  
20                   under the same provisions and in the same  
21                   way, subject to subparagraph (B), as a  
22                   joint resolution under section 2908 of the  
23                   Defense Base Closure and Realignment  
24                   Act of 1990 (10 U.S.C. 2678 note).

1 (B) SPECIAL RULES.—For purposes of ap-  
2 plying subparagraph (A) with respect to such  
3 provisions, the following rules shall apply:

4 (i) Section 2908(a) of the Defense  
5 Base Closure and Realignment Act of  
6 1990 (10 U.S.C. 2678 note) shall not  
7 apply.

8 (ii) Any reference to the resolution de-  
9 scribed in subparagraph (A) shall be  
10 deemed to be a reference to the bill sub-  
11 mitted under paragraph (3).

12 (iii) Any reference to the Committee  
13 on National Security of the House of Rep-  
14 resentatives shall be deemed to be a ref-  
15 erence to the Committee on Ways and  
16 Means of the House of Representatives  
17 and any reference to the Committee on  
18 Armed Services of the Senate shall be  
19 deemed to be a reference to the Committee  
20 on Finance of the Senate.

21 (iv) Any reference to the date on  
22 which the President transmits a report  
23 shall be deemed to be a reference to the  
24 date on which the implementing bill is sub-  
25 mitted under paragraph (3).

1 (v) Notwithstanding section  
2 2908(d)(2) of the Act—

3 (I) debate on the bill in the  
4 House of Representatives, and on all  
5 debatable motions and appeals in con-  
6 nection with the bill, shall be limited  
7 to not more than 10 hours, divided  
8 equally between those favoring and  
9 those opposing the bill;

10 (II) debate on the bill in the Sen-  
11 ate, and on all debatable motions and  
12 appeals in connection with the bill,  
13 shall be limited to not more than 10  
14 hours, divided equally between those  
15 favoring and those opposing the bill;  
16 and

17 (III) debate in the Senate on any  
18 single debatable motion and appeal in  
19 connection with the bill shall be lim-  
20 ited to not more than 1 hour, divided  
21 equally between the proponent of the  
22 motion and the manager of the bill,  
23 except that if the manager of the bill  
24 is in favor of the motion or appeal,  
25 the time in opposition to the motion



1 or appeal shall be controlled by the  
2 Minority Leader or the Leader's des-  
3 ignee, and the Majority and Minority  
4 Leader may each allot additional time  
5 from time under such Leader's control  
6 to any Senator during the consider-  
7 ation of any debatable motion or ap-  
8 peal.

9 (c) WAIVER AUTHORITY.—The Secretary shall waive  
10 compliance with the requirements of titles XI, XVIII, and  
11 XIX of the Social Security Act (42 U.S.C. 1301 et seq.,  
12 1395 et seq., 1396 et seq.) to such extent and for such  
13 period as the Secretary determines is necessary to conduct  
14 demonstration projects under this section.

15 (d) DURATION.—A demonstration project under this  
16 section shall be conducted for a period to be determined  
17 by the Secretary of Health and Human Services except  
18 that the demonstration project shall not be conducted  
19 after December 31, 2002. The Secretary may terminate  
20 a project if the Secretary determines that the consortium  
21 conducting the project is not in substantial compliance  
22 with the terms of the application approved by the Sec-  
23 retary.

24 (e) FUNDING.—The Secretary shall provide for the  
25 transfer from the Federal Hospital Insurance Trust Fund

1 and the Federal Supplementary Insurance Trust Fund  
 2 under title XVIII of the Social Security Act (42 U.S.C.  
 3 1395i, 1395t), in such proportions as the Secretary deter-  
 4 mines to be appropriate, of such funds as are necessary  
 5 for the costs of carrying out the demonstration projects  
 6 under this section.

## 7 **TITLE II—INCREASE IN** 8 **FLEXIBILITY UNDER MEDICARE**

### 9 **SEC. 201. COMPETITIVE BIDDING.**

10 (a) GENERAL RULE.—Part B of title XVIII (42  
 11 U.S.C. 1395j et seq.) is amended by inserting after section  
 12 1846 the following:

### 13 **“SEC. 1847. COMPETITIVE ACQUISITION OF ITEMS AND** 14 **SERVICES.**

15 “(a) ESTABLISHMENT OF BIDDING AREAS.—

16 “(1) IN GENERAL.—The Secretary shall estab-  
 17 lish competitive acquisition areas for contract award  
 18 purposes for the furnishing under this part of the  
 19 items and services described in subsection (c). The  
 20 Secretary may establish different competitive acqui-  
 21 sition areas under this subsection for different class-  
 22 es of items and services.

23 “(2) CRITERIA FOR ESTABLISHMENT.—The  
 24 competitive acquisition areas established under para-  
 25 graph (1) shall be chosen based on the availability

1 and accessibility of entities able to furnish items and  
2 services, and the probable savings to be realized by  
3 the medicare program established under this title  
4 from the use of competitive bidding in the furnishing  
5 of items and services in the area.

6 “(b) AWARDING OF CONTRACTS IN AREAS.—

7 “(1) IN GENERAL.—The Secretary shall con-  
8 duct a competition among individuals and entities  
9 supplying items and services described in subsection  
10 (c) for each competitive acquisition area established  
11 under subsection (a) for each class of items and  
12 services.

13 “(2) CONDITIONS FOR AWARDING CONTRACT.—

14 The Secretary may not award a contract to any en-  
15 tity under the competition conducted pursuant to  
16 paragraph (1) to furnish an item or service unless  
17 the Secretary finds that the entity meets quality  
18 standards specified by the Secretary, and that the  
19 total amounts to be paid under the contract are ex-  
20 pected to be less than the total amounts that would  
21 otherwise be paid.

22 “(3) CONTENTS OF CONTRACT.—A contract en-  
23 tered into with an individual or an entity under the  
24 competition conducted pursuant to paragraph (1) is

1 subject to terms and conditions that the Secretary  
2 may specify.

3 “(4) LIMIT ON NUMBER OF CONTRACTORS.—

4 The Secretary may limit the number of contractors  
5 in a competitive acquisition area to the number  
6 needed to meet projected demand for items and serv-  
7 ices covered under the contracts.

8 “(c) SERVICES DESCRIBED.—The items and services  
9 to which this section applies are all items and services cov-  
10 ered under this part (except for physician services as de-  
11 fined in section 1861(r)) that the Secretary may specify.”.

12 (b) ITEMS AND SERVICES TO BE FURNISHED ONLY  
13 THROUGH COMPETITIVE ACQUISITION.—Section 1862(a)  
14 (42 U.S.C. 1395y(a)) is amended—

15 (1) by striking “or” at the end of paragraph  
16 (15),

17 (2) by striking the period at the end of para-  
18 graph (16) and inserting “; or”, and

19 (3) by inserting after paragraph (16) the fol-  
20 lowing:

21 “(17) where the expenses are for an item or  
22 service furnished in a competitive acquisition area  
23 (as established by the Secretary under section  
24 1847(a)) by an entity other than an entity with  
25 which the Secretary has entered into a contract

1 under section 1847(b) for the furnishing of such an  
 2 item or service in that area, unless the Secretary  
 3 finds that the expenses were incurred in a case of  
 4 urgent need, or in other circumstances specified by  
 5 the Secretary.”.

6 (c) EFFECTIVE DATE.—The amendments made by  
 7 subsections (a) and (b) shall apply to items and services  
 8 furnished on and after October 1, 1997.

9 **SEC. 202. FLEXIBLE PURCHASING.**

10 Title XVIII (42 U.S.C. 1395 et seq.) is amended by  
 11 adding at the end the following:

12 “FLEXIBLE PURCHASING

13 “SEC. 1894. (a) IN GENERAL.—The Secretary may  
 14 enter into contracts with providers of services, physicians,  
 15 and other entities and individuals that furnish items or  
 16 services under the medicare program established under  
 17 this title under which the Secretary may utilize—

18 “(1) alternative claims processing, administra-  
 19 tive, and related procedures; and

20 “(2) reduced payment rates or alternative pay-  
 21 ment methodologies.

22 “(b) SAVINGS TO BENEFICIARIES.—Contracts under  
 23 this section may provide for reductions in payments re-  
 24 quired from individuals entitled to benefits under this title.

1       “(c) REQUIREMENTS UNDER A CONTRACT UNDER  
2 THIS SECTION.—The following requirements shall apply  
3 to any contract entered into pursuant to this section:

4           “(1) The provisions of subtitle B of title XI,  
5 other provisions concerned with quality of care, and  
6 conditions of participation shall apply unchanged.

7           “(2) The Secretary shall certify that the  
8 amounts to be paid under such a contract are less  
9 than the amounts that otherwise would be paid  
10 under this title.

11          “(3) Individuals entitled to benefits under this  
12 title may not be required to pay more for services  
13 provided pursuant to such a contract than the  
14 amounts that such individuals would otherwise be  
15 required to pay under this title.

16          “(4) The contract shall be for a fixed term (but  
17 may be renewed).

18          “(5) The terms of the contract shall be subject  
19 to periodic review by the Secretary.

20       “(d) WAIVER OF COMPETITION REQUIREMENTS.—  
21 The Secretary may waive the applicability of any otherwise  
22 applicable competitive procedures (as defined in section  
23 4(5) of the Office of Federal Procurement Policy Act (41  
24 U.S.C. 403(5)) to any contract entered into under this  
25 section.”.

1 **SEC. 203. REPORT ON USE OF NEW AUTHORITIES.**

2 (a) IN GENERAL.—Not later than 2 years after the  
3 date of enactment of this Act, and biennially thereafter  
4 for 6 years, the Secretary of Health and Human Services  
5 shall report to Congress on the implementation and results  
6 of the amendments made to title XVIII of the Social Secu-  
7 rity Act (42 U.S.C. 1395 et seq.) by this title.

8 (b) CONTENTS OF REPORT.—Each report described  
9 in subsection (a) shall contain a detailed description of the  
10 impact of such amendments on expenditures for, access  
11 to, and quality of items and services provided under the  
12 medicare program under title XVIII of the Social Security  
13 Act (42 U.S.C. 1395 et seq.).

14 **TITLE III—QUALITY IN**  
15 **MEDIHEALTH PLANS**

16 **SEC. 301. DEFINITIONS.**

17 In this title:

18 (1) COMPARATIVE REPORT.—The term “com-  
19 parative report” means the comparative report de-  
20 veloped under section 1895C(e) of the Social Secu-  
21 rity Act (as added by section 101 of this Act).

22 (2) DIRECTOR.—The term “Director” means  
23 the Director of the Office of Competition within the  
24 Department of Health and Human Services as es-  
25 tablished under section 1895M(a) of the Social Se-  
26 curity Act (as added by section 101 of this Act).

1           (3) MEDICARE PROGRAM.—The term “medicare  
2           program” means the program of health care benefits  
3           provided under title XVIII of the Social Security Act  
4           (42 U.S.C. 1395 et seq.).

5           (4) MEDIHEALTH PLAN.—The term  
6           “MediHealth plan” has the meaning given the term  
7           in section 1895A(a)(1) of the Social Security Act (as  
8           added by section 101 of this Act).

9           (5) MEDIHEALTH PLAN SPONSOR.—The term  
10          “MediHealth plan sponsor” has the meaning given  
11          the term in section 1895A(a)(2) of the Social Secu-  
12          rity Act (as added by section 101 of this Act).

13 **SEC. 302. QUALITY ADVISORY INSTITUTE.**

14          (a) ESTABLISHMENT.—There is established an Insti-  
15          tute to be known as the “Quality Advisory Institute” (in  
16          this title referred to as the “Institute”) to make rec-  
17          ommendations to the Director concerning licensing and  
18          certification criteria and comparative measurement meth-  
19          ods under this title.

20          (b) MEMBERSHIP.—

21               (1) COMPOSITION.—The Institute shall be com-  
22          posed of 5 members to be appointed by the Director  
23          from among individuals who have demonstrable ex-  
24          pertise in—

25                       (A) health care quality measurement;



1 (B) health plan certification criteria set-  
 2 ting;

3 (C) the analysis of information that is use-  
 4 ful to consumers in making choices regarding  
 5 health coverage options, health plans, health  
 6 care providers, and decisions regarding health  
 7 treatments; and

8 (D) the analysis of health plan operations.

9 (2) TERMS AND VACANCIES.—The members of  
 10 the Institute shall be appointed for 5-year terms  
 11 with the terms of the initial members staggered as  
 12 determined appropriate by the Director. Vacancies  
 13 shall be filled in a manner provided for by the Direc-  
 14 tor.

15 (c) DUTIES.—The Institute shall—

16 (1) not later than 1 year after the date on  
 17 which all members of the Institute are appointed  
 18 under subsection (b)(2), provide advice to the Direc-  
 19 tor concerning the initial set of criteria for the cer-  
 20 tification of MediHealth plans;

21 (2) analyze the use of the criteria for the cer-  
 22 tification of MediHealth plans implemented by the  
 23 Director under this title and recommend modifica-  
 24 tions in such criteria as needed;

1           (3) analyze the use of the comparative measure-  
2           ments implemented by the Director in developing  
3           comparative reports and recommend modifications in  
4           such measurements as needed;

5           (4) perform, or enter into contracts with other  
6           entities for the performance of, an analysis of access  
7           to services and clinical outcomes based on patient  
8           encounter data;

9           (5) enter into contracts with other entities for  
10          the development of such criteria and measurements  
11          and to otherwise carry out its duties under this sec-  
12          tion; and

13          (6) carry out any other activities determined  
14          appropriate by the Institute to carry out its duties  
15          under this section.

16 The analysis described in paragraph (4) should focus on  
17 conditions and procedures of significance to beneficiaries  
18 under the medicare program, as determined by the Insti-  
19 tute, and should be designed, and the results summarized,  
20 in a manner that facilitates comparisons across health  
21 plans.

22          (d) COMPENSATION OF MEMBERS.—Section 5315 of  
23 title 5, United States Code, is amended by adding at the  
24 end the following:

25                 “Member, Quality Advisory Institute”.

1       (e) CONFLICT OF INTEREST.—No member of the In-  
2       stitute shall engage in any other business, vocation, or em-  
3       ployment than that of serving as a member of the Insti-  
4       tute, nor shall any such member participate, directly or  
5       indirectly, in any operations or transactions of a character  
6       subject to regulation by the Institute pursuant to this title.

7       (f) STAFF.—The Institute may appoint and fix the  
8       compensation of such officers and other experts and em-  
9       ployees as may be necessary for carrying out the functions  
10      of the Institute under this title and shall fix the salaries  
11      of such officers, experts, and employees in accordance with  
12      chapter 51 and subchapter III of chapter 53 of title 5,  
13      United States Code.

14      (g) DETAIL OF GOVERNMENT EMPLOYEES.—Any  
15      Federal Government employee may be detailed to the In-  
16      stitute without reimbursement (other than the regular  
17      compensation of the employee), and such detail shall be  
18      without interruption or loss of civil service status or privi-  
19      lege.

20      (h) CONTRACTING AUTHORITY.—Notwithstanding  
21      any other provision of law, the Institute may enter directly  
22      into contracts with entities as the Institute determines  
23      necessary to carry out the functions of the Institute under  
24      this title.

1       (i) **PROCUREMENT OF TEMPORARY AND INTERMIT-**  
2 **TENT SERVICES.**—The members of the Institute may pro-  
3 cure temporary and intermittent services under section  
4 3109(b) of title 5, United States Code, at rates for individ-  
5 uals which do not exceed the daily equivalent of the annual  
6 rate of basic pay prescribed for level V of the Executive  
7 Schedule under section 5316 of such title.

8       (j) **LEASING AUTHORITY.**—Notwithstanding any  
9 other provision of law, the Institute may enter directly into  
10 leases for real property for office, meeting, storage, and  
11 such other space as may be necessary to carry out the  
12 functions of the Institute under this title, and shall be ex-  
13 empt from any General Services Administration space  
14 management regulations or directives.

15       (k) **ACCEPTANCE OF PAYMENTS.**—

16           (1) **IN GENERAL.**—Notwithstanding any other  
17 provision of law, in accordance with regulations  
18 which the Institute shall prescribe to prevent con-  
19 flicts of interest, the Institute may accept payment  
20 and reimbursement, in cash or in kind, from non-  
21 Federal agencies, organizations, and individuals for  
22 travel, subsistence, and other necessary expenses in-  
23 curred by members of the Institute in attending  
24 meetings and conferences concerning the functions  
25 or activities of the Institute.

1           (2) CREDIT OF ACCOUNT.—Any payment or re-  
 2           imbursement accepted shall be credited to the appro-  
 3           priated funds of the Institute.

4           (3) AMOUNT.—The amount of travel, subsist-  
 5           ence, and other necessary expenses for members and  
 6           employees paid or reimbursed under this subsection  
 7           may exceed per diem amounts established in official  
 8           travel regulations, but the Institute may include in  
 9           its regulations under this subsection a limitation on  
 10          such amounts.

11 **SEC. 303. DUTIES OF DIRECTOR.**

12          (a) IN GENERAL.—The Director shall—

13           (1) adopt, adapt, or develop criteria in accord-  
 14           ance with sections 306 through 309 to be used in  
 15           the licensing of certifying entities and in the certifi-  
 16           cation of MediHealth plans, including any minimum  
 17           criteria needed for the operation of MediHealth  
 18           plans during the transition period described in sec-  
 19           tion 306(c);

20           (2) issue licenses to certifying entities that meet  
 21           the criteria developed under paragraph (1) for the  
 22           purpose of enabling such entities to certify  
 23           MediHealth plans in accordance with this title;

24           (3) develop comparative health care measures in  
 25           addition to those implemented by the Director in de-

1        veloping comparative reports in order to guide  
2        consumer choice under the medicare program and to  
3        improve the delivery of quality health care under  
4        such program;

5            (4) develop procedures, consistent with part D  
6        of the Social Security Act (as added by section 101  
7        of this Act), for the dissemination of certification  
8        and comparative quality information provided to the  
9        Director;

10           (5) contract with an independent entity for the  
11        conduct of audits concerning certification and qual-  
12        ity measurement and require that as part of the cer-  
13        tification process performed by licensed certification  
14        entities that there include an onsite evaluation,  
15        using performance-based standards, of the providers  
16        of items and services under a MediHealth plan;

17           (6) at least quarterly, meet jointly with the  
18        Agency for Health Care Policy and Research to re-  
19        view innovative health outcomes measures, new  
20        measurement processes, and other matters deter-  
21        mined appropriate by the Director;

22           (7) at least annually, meet with the Institute  
23        concerning certification criteria;

24           (8) not later than January 1, 1999, and each  
25        January 1 thereafter, prepare and submit to

1 MediHealth plan sponsors and to Congress, a report  
 2 concerning the activities of the Director for the pre-  
 3 vious year;

4 (9) advise the President and Congress concern-  
 5 ing health insurance and health care provided under  
 6 MediHealth plans and make recommendations con-  
 7 cerning measures that may be implemented to pro-  
 8 tect the health of all enrollees in MediHealth plans;  
 9 and

10 (10) carry out other activities determined ap-  
 11 propriate by the Director.

12 (b) RULE OF CONSTRUCTION.—Nothing in this sec-  
 13 tion shall be construed to limit the authority of the Direc-  
 14 tor or the Secretary of Health and Human Services with  
 15 respect to requirements other than those applied under  
 16 this title with respect to MediHealth plans.

17 **SEC. 304. COMPLIANCE.**

18 (a) IN GENERAL.—Not later than January 1, 1999,  
 19 the Director shall ensure that a MediHealth plan may not  
 20 be offered unless it has been certified in accordance with  
 21 this title.

22 (b) CONTRACTS OR REIMBURSEMENTS.—In carrying  
 23 out subsection (a), the Director—

24 (1) may not enter into a contract with a  
 25 MediHealth plan sponsor for the provision of a

1 MediHealth plan unless the MediHealth plan is cer-  
 2 tified in accordance with this title;

3 (2) may not reimburse a MediHealth plan spon-  
 4 sor for items and services provided under a  
 5 MediHealth plan unless the MediHealth plan is cer-  
 6 tified in accordance with this title; and

7 (3) shall, after providing notice to the  
 8 MediHealth plan sponsor operating a MediHealth  
 9 plan and an opportunity for such MediHealth plan  
 10 to be certified, and in accordance with any applica-  
 11 ble grievance and appeals procedures under section  
 12 309, terminate any contract with a MediHealth plan  
 13 sponsor for the operation of a MediHealth plan if  
 14 such MediHealth plan is not certified in accordance  
 15 with this title.

16 **SEC. 305. PAYMENTS FOR VALUE.**

17 (a) ESTABLISHMENT OF PROGRAM.—The Director  
 18 shall establish a program under which payments are made  
 19 to various MediHealth plans to reward such plans for  
 20 meeting or exceeding quality targets.

21 (b) PERFORMANCE MEASURES.—In carrying out the  
 22 program under subsection (a), the Director shall establish  
 23 broad categories of quality targets and performance meas-  
 24 ures. Such targets and measures shall be designed to per-



1 mit the Director to determine whether a MediHealth plan  
 2 is being operated in a manner consistent with this title.

3 (c) USE OF FUNDS.—The Director shall use amounts  
 4 allocated under section 1895M(k) of the Social Security  
 5 Act (as added by subsection (e)) to make annual payments  
 6 to those MediHealth plans that have been determined by  
 7 the Director to meet or exceed the quality targets and per-  
 8 formance measures established under subsection (b). Any  
 9 amounts allocated under such section for a fiscal year and  
 10 remaining available after payments are made under sub-  
 11 section (d), shall be used for deficit reduction.

12 (d) AMOUNT OF PAYMENT.—

13 (1) FORMULA.—The amount of any payment  
 14 made to a MediHealth plan under this section shall  
 15 be determined in accordance with a formula to be  
 16 developed by the Director. The formula shall ensure  
 17 that a payment made to a MediHealth plan under  
 18 this section be in an amount equal to—

19 (A) with respect to a MediHealth plan that  
 20 is determined to be in the first quintile, 1 per-  
 21 cent of the amount allocated by the plan under  
 22 section 1895M(k) of the Social Security Act (as  
 23 added by subsection (e));

24 (B) with respect to a MediHealth plan that  
 25 is determined to be in the second quintile, 0.75

1           percent of the amount allocated by the plan  
2           under such section;

3           (C) with respect to a MediHealth plan that  
4           is determined to be in the third quintile, 0.50  
5           percent of the amount allocated by the plan  
6           under such section; and

7           (D) with respect to a MediHealth plan that  
8           is determined to be in the fourth quintile, 0.25  
9           percent of the amount allocated by the plan  
10          under such section.

11          (2) NO PAYMENT.—A MediHealth plan that is  
12          determined by the Director to be in the fifth quintile  
13          shall not be eligible to receive a payment under this  
14          section.

15          (3) DETERMINATION OF QUINTILES.—Not later  
16          than April 30 of each calendar year, the Director  
17          shall rank each MediHealth plan based on the per-  
18          formance of the plan during the preceding year as  
19          determined using the quality targets and perform-  
20          ance measures established under subsection (b).  
21          Such rankings shall be divided into quintiles with  
22          the first quintile containing the highest ranking  
23          plans and the fifth quintile containing the lowest  
24          ranking plans. Each such quintile shall contain plans

1       that in the aggregate cover an equal number of  
2       beneficiaries as compared to another quintile.

3       (e) **MEDIHEALTH PLANS.**—Section 1895O of the So-  
4       cial Security Act (as added by section 101 of this Act)  
5       is amended by adding at the end the following:

6       “(d) **WITHHOLDING OF PAYMENTS TO ENCOURAGE**  
7       **QUALITY PERFORMANCE.**—

8               “(1) **WITHHOLDING.**—For each MediHealth  
9       plan, the Secretary shall withhold 0.50 percent from  
10      any payment that a MediHealth plan sponsor under  
11      this part receives with respect to an individual en-  
12      rolled with such plan with the plan sponsor.

13             “(2) **DISBURSEMENT.**—From the total amount  
14      withheld under paragraph (1), the Secretary shall  
15      make payments to MediHealth plan sponsors under  
16      this part in accordance with the formula established  
17      by the Director of the Office of Competition within  
18      the Department of Health and Human Services  
19      under section 305(d) of the Comprehensive Medicare  
20      Reform and Improvement Act of 1997.”.

21   **SEC. 306. CERTIFICATION REQUIREMENT.**

22       (a) **IN GENERAL.**—To be eligible to enter into a con-  
23      tract with the Director to enroll individuals in a  
24      MediHealth plan, a MediHealth plan sponsor shall partici-  
25      pate in the certification process and have the MediHealth

1 plans offered by such plan sponsor certified in accordance  
2 with this title.

3 (b) EFFECT OF MERGERS OR PURCHASE.—

4 (1) CERTIFIED PLANS.—Where 2 or more  
5 MediHealth plan sponsors offering certified  
6 MediHealth plans are merged or where 1 such plan  
7 sponsor is purchased by another plan sponsor, the  
8 resulting plan sponsor may continue to operate and  
9 enroll individuals for coverage under the MediHealth  
10 plan as if the MediHealth plan involved were cer-  
11 tified. The certification of any resulting MediHealth  
12 plan shall be reviewed by the applicable certifying  
13 entity to ensure the continued compliance of the con-  
14 tract with the certification criteria.

15 (2) NONCERTIFIED PLANS.—The certification  
16 of a MediHealth plan shall be terminated upon the  
17 merger of the MediHealth plan sponsor involved or  
18 the purchase of the plan sponsor by another entity  
19 that does not offer any certified MediHealth plans.  
20 Any MediHealth plans offered through the resulting  
21 plan sponsor may reapply for certification after the  
22 completion of the merger or purchase.

23 (c) TRANSITION FOR NEW PLANS.—

24 (1) IN GENERAL.—A MediHealth plan that has  
25 not provided health insurance coverage to individuals

1 prior to the effective date of this Act shall be per-  
2 mitted to contract with the Director and operate and  
3 enroll individuals under a MediHealth plan without  
4 being certified for the 2-year period beginning on the  
5 date on which such MediHealth plan sponsor enrolls  
6 the first individual in the MediHealth plan. Such  
7 MediHealth plan must be certified in order to con-  
8 tinue to provide coverage under the contract after  
9 such period.

10 (2) LIMITATION.—A new MediHealth plan de-  
11 scribed in paragraph (1) shall, during the period re-  
12 ferred to in paragraph (1) prior to certification,  
13 comply with the minimum criteria developed by the  
14 Director under section 306(a)(1).

15 **SEC. 307. LICENSING OF CERTIFICATION ENTITIES.**

16 (a) IN GENERAL.—The Director shall develop proce-  
17 dures for the licensing of entities to certify MediHealth  
18 plans under this title.

19 (b) REQUIREMENTS.—The procedures developed  
20 under subsection (a) shall ensure that—

21 (1) to be licensed under this section a certifi-  
22 cation entity shall apply the requirements of this  
23 title to MediHealth plans seeking certification;

24 (2) a certification entity has procedures in place  
25 to suspend or revoke the certification of a

1 MediHealth plan that is failing to comply with the  
 2 certification requirements; and

3 (3) the Director will give priority to licensing  
 4 entities that are accrediting health plans that con-  
 5 tract with the Director on the date of enactment of  
 6 this Act.

7 **SEC. 308. CERTIFICATION CRITERIA.**

8 (a) ESTABLISHMENT.—The Director shall establish  
 9 minimum criteria under this section to be used by licensed  
 10 certifying entities in the certification of MediHealth plans  
 11 under this title.

12 (b) REQUIREMENTS.—Criteria established by the Di-  
 13 rector under subsection (a) shall require that, in order to  
 14 be certified, a MediHealth plan shall comply at a minimum  
 15 with the following:

16 (1) QUALITY IMPROVEMENT PLAN.—The  
 17 MediHealth plan shall implement a total quality im-  
 18 provement plan that is designed to improve the clini-  
 19 cal and administrative processes of the MediHealth  
 20 plan on an ongoing basis and demonstrate that im-  
 21 provements in the quality of items and services pro-  
 22 vided under the MediHealth plan have occurred as  
 23 a result of such improvement plan.

24 (2) PROVIDER CREDENTIALS.—The MediHealth  
 25 plan shall compile and annually provide to the li-

1 censed certifying entity documentation concerning  
2 the credentials of the hospitals, physicians, and  
3 other health care professionals reimbursed under the  
4 MediHealth plan.

5 (3) COMPARATIVE INFORMATION.—The  
6 MediHealth plan shall compile and provide, as re-  
7 quested by the Secretary of Health and Human  
8 Services, to the such Secretary the information nec-  
9 essary to develop a comparative report.

10 (4) ENCOUNTER DATA.—The MediHealth plan  
11 shall maintain patient encounter data in accordance  
12 with standards established by the Institute, and  
13 shall provide these data, as requested by the Insti-  
14 tute, to the Institute in support of conducting the  
15 analysis described in section 302(c)(4).

16 (5) OTHER REQUIREMENTS.—The MediHealth  
17 plan shall comply with other requirements author-  
18 ized under this title and implemented by the Direc-  
19 tor.

20 **SEC. 309. GRIEVANCE AND APPEALS.**

21 The Director shall develop grievance and appeals pro-  
22 cedures under which a MediHealth plan that is denied cer-  
23 tification under this title may appeal such denial to the  
24 Director.

